

Place patient label here

PATHOLOGY ASSOCIATES

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PATIENT INFORMATION

CLINICAL HISTORY _____

PRE-OP DIAGNOSIS _____

POST-OP DIAGNOSIS _____

PREVIOUS PERTINENT DIAGNOSIS _____

SURGERY INFORMATION

DATE COLLECTED _____ TIME COLLECTED _____ RN SIGNATURE _____

OPERATING PHYSICIAN _____ COPIES TO PHYSICIAN _____

SURGICAL PROCEDURE _____

SITE OF SPECIMEN(S) SUBMITTED FOR PROCESSING

A) _____

B) _____

C) _____

D) _____

E) _____

F) _____

FROZEN SECTION: **TIME STARTED:** **TIME ENDED:** _____

FROZEN SECTION DIAGNOSIS: _____

FOR PATHOLOGY DEPARTMENT USE ONLY

DATE RECEIVED	TOTAL SPECIMEN(S)	PATIENT NAME VERIFICATION	(INT)
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QUALITY ASSESSMENT		COMPLETE	INCOMPLETE
INCOMPLETE CLINICAL HX	INCOMPLETE PT DEMOGRAPHICS	PHYSICIAN NOT GIVEN	INADEQUATE FIXATIVE
SITE NOT STATED ON REQ/CONT	CONTAINER UNLABELED	DISCREPANCY NOTED (EXPLAIN)	OTHER (EXPLAIN)