

**VETERINARY DIAGNOSTIC CENTER
Surgical Pathology Submission Form**

Fair Street and East Campus Loop
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Office Use Only	
Accession Number	
Date Rec'd _____	Case Coordinator _____
Date Results Faxed _____	Date Results Phoned _____
Invoice _____	Referral No. _____

Veterinarian:			Owner:		
Clinic:			Address:		
Address:			City:	State:	Zip:
City:	State:	Zip:	Phone:	Date Mailed:	
Phone:	Fax:	Send Results By: <input type="checkbox"/> Mail		<input type="checkbox"/> Fax	<input type="checkbox"/> E-mail
Reports Results to: <input type="checkbox"/> Veterinarian <input type="checkbox"/> Owner/Producer <input type="checkbox"/> Third Party			Third Party Address:		
Person to be Billed: <input type="checkbox"/> Veterinarian <input type="checkbox"/> Owner/Producer <input type="checkbox"/> Third Party			City:	State:	Zip:

Animal: (Please list data for the animal(s) submitted rather than a general description of the herd or group) For multiple animals use the space on the back of the form

Species	Breed	<input type="checkbox"/> Male <input type="checkbox"/> Female	Animal I.D.	Age
		<input type="checkbox"/> Neutered/Spay		<input type="checkbox"/> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years

Neoplasms

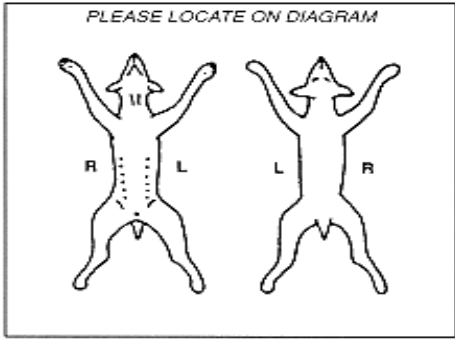
Location:
Description:
Growth Pattern and Rate:
Duration:

Dermatitis Cases

Duration of Problem:	Pruritic: <input type="checkbox"/>	Non-Pruritic: <input type="checkbox"/>
Clinical Signs:		
Treatment and Response:		

Distribution

Description

<p>PLEASE LOCATE ON DIAGRAM</p> 	
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Lab Use Only

Sample Integrity: <input type="checkbox"/> Good <input type="checkbox"/> Broken <input type="checkbox"/> Missing Initials _____	<input type="checkbox"/> Called Vet Date _____ Time _____ By _____
Comments _____	
Histology: Tumor _____ Site _____ Blk/Tissue _____	AS