

For lab use only:
JW ____ - ____

Containers received: ____
Cassettes used: ____



DERMATOPATHOLOGY REQUEST FORM

www.specialtyvetpath.com

PH: 206-245-8426

FAX: 206-453-3309

Jennifer G. Ward, DVM, DACVP

Pamela E. Ginn, DVM, DACVP

Date sample(s) taken: _____ Owner's name: _____
Clinic: _____ Animal's name: _____
Clinician: _____ Species: _____ Sex _____
Address: _____ Breed/color: _____
City/St/Zip: _____ Age or DOB: _____
Ph/Fax: _____ Previous submissions: _____
Email: _____ Clinical diagnosis: _____

How would you like to receive results? Fax Email Both

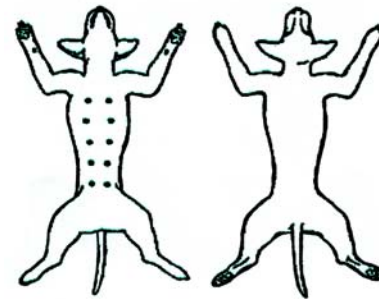
Photos can be sent electronically to: info@specialtyvetpath.com

Biopsy 1: _____ Biopsy 2: _____

Biopsy 3: _____ Biopsy 4: _____

Biopsy 5: _____ Biopsy 6: _____

Clinical history (include gross description of lesions & results of relevant diagnostic testing):



VENTRAL

DORSAL

Ship samples to:
SpecialtyVETPATH
520 N 74th St.
Seattle WA 98103