

For lab use only:
JW ___-_____

Containers received:____
Cassettes used: _____


SURGICAL PATHOLOGY 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: _____
Clinic: _____
Clinician: _____
Address: _____
City/state/zip: _____
Phone: _____ Fax: _____
Email: _____

Owner's name: _____
Animal's name: _____
Species: _____ Sex: _____
Breed/color: _____
Age/DOB: _____
Previous submissions: _____
Clinical diagnosis: _____

How would you like to receive results? Fax Email Both

Number of containers: _____ Number of specimens: _____ Number of sites _____

Sample types: Incisional Excisional Endoscopy Needle

Specimen description/site: _____

Clinical History:

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