Patient Name: **Sex:**
Species: **Age:**
Breed:
Client Name:
Clinic Name:
Clinic Address:

Clinic Phone:
Clinic Fax:

VETERINARY MEDICAL TEACHING HOSPITAL
UNIVERSITY OF CALIFORNIA, DAVIS

PATHOLOGY NO.

OCULAR PATHOLOGY SERVICE REQUEST

DATE TAKEN

PRIMARY CLINICIAN

DATE REC'D

PATHOLOGIST Reilly

BIOPSY TISSUES SUBMITTED:

CHARGE TO:
☐ CLINIC ☐ COUPON: _____
☐ SPECIAL INTEREST (APPROVAL REQUIRED)

BIOPSY ☐ (No of jars _____ ; No of sites _____)

SPECIAL REQUESTS (photos, special interest, margins, etc)
☐ GROSS PHOTOS (may delay report) ☐ EXTRA SLIDE
☐ MARGINS
☐ EXAMINE LIDS
☐ IOL
☐ PREVIOUS EVISCERATION/SCLERAL PROSTHESIS
☐ EVISCERATION SAMPLE
☐ OTHER:
_____

DO NOT WRITE IN SHADED AREAS
☐ Biopsy (1-2 sample sites)
☐ Biopsy (3-5 sample sites)
☐ Biopsy (add'l sample sites) x _____
☐ Referral Slide
☐ Large Slide (extra charge)
☐ Misc. Pathology Services
$_____

☐ PRIOR BIOPSY? IF YES, BIOPSY ACCESSION # _____

Indicate clinicopathologic correlations of particular interest to you:

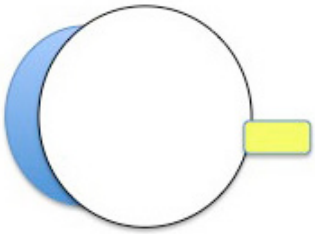
PAST MEDICAL HISTORY (if relevant) – Prior illness, surgery, immunizations, etc.

PRESENT ILLNESS – Signs (GLAUCOMA?), course/duration, ocular exam, treatments, IOP, staging. etc.

LESION MAP – IDENTIFY REGIONS OF PARTICULAR INTEREST, if applicable. Add lids/lens if needed.

OD

OS



Clinical diagnosis _____

Clinician signature _____