Alberta Health Services

Calgary Laboratory Services

REQUEST FOR INTRA-OPERATIVE PATHOLOGY CONSULTATION

Scanning Label or Accession # *(lab only)*

Patient

PHN Expiry:	Date of Birth *(dd-Mon-yyyy)*		
Legal Last Name	Legal First Name	Middle Name	
Alternate Identifier	Preferred Name	☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to disclose	Phone
Address	City/Town	Prov	Postal Code

Provider (s)

Authorizing Provider Name *(last, first, middle)*			Copy to Name *(last, first, middle)*	Copy to Name *(last, first, middle)*
Address		Phone	Address	Address
CC Provider ID	CC Submitter ID	Legacy ID	Phone	Phone
Clinic Name			Clinic Name	Clinic Name

Collection	Date *(dd-Mon-yyyy)*	Time *(24 hr)*	Location	Collector ID

MAXIMUM TWO (2) SPECIMENS MAY BE SUBMITTED ON EACH REQUISITION

* **Specimens Submitted / Exact Site(s) and Time(s) Removed From Patient:**

* **Clinical History:** Is this a potential Infectious Case? ☐ Yes ☐ No * **Previous Radiation/Chemotherapy:** ☐ Yes ☐ No

List Relevant Medications: _____

LAB USE ONLY:

Gross Description:

Frozen Section (Microscopic):

Intra-Operative Diagnosis:

TIME IN:

TIME OUT:

Initials of Pathologist Consulted:

Initials of FS cutter: _____

# of FS blocks: _____

Received:

Authorized to be put in formalin by: _____

Date/Time placed in formalin: _____

Pathologist: _____ _____
Print Name Signature

Touch Preps: ☐ No ☐ Yes Flow Cytometry: ☐ No ☐ Yes

Tumor Bank: ☐ No ☐ Yes Lymphoma Protocol: ☐ No ☐ Yes

Photos: ☐ No ☐ Yes Cytogenetics: ☐ No ☐ Yes

EM: ☐ No ☐ Yes Other: _____