Alberta Health Services

Calgary Laboratory Services

☐ ACH ☐ RGH
☐ FMC ☐ PLC
☐ WHC ☐ SHC
☐ OTHER: _____

# REQUEST FOR INTRA-OPERATIVE PATHOLOGY CONSULTATION

* REQUIRED INFORMATION

**SURGEON:**

_____ _____
* Last Name * Full First Name

_____
* Office Address (Location Code) for Report Delivery

**Phone results to O.R. THEATRE / ROOM #:** _____

* Affix addressograph imprint or patient label to **ALL PAGES** or clearly print patient's full name (last name, full first name), Personal Health Number, Medical Record Number, date of birth, and gender.

* DATE OF SURGERY:

___ ___ ___ ___ / ___ ___ ___ / ___ ___
Y Y Y Y M M M D D

ACCESSION NUMBER (Lab Use Only)

**ADDITIONAL COPIES TO:**

1) _____ _____ _____
* Last Name * Full First Name * Office Address (Location Code) for Report Delivery

2) _____ _____ _____
* Last Name * Full First Name * Office Address (Location Code) for Report Delivery

## 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: _____

Pathologist: _____ _____
Print Name Signature

Received:

Authorized to be put in formalin by: _____

Date/Time placed in formalin: _____

Touch Preps: ☐ No ☐ Yes
Tumor Bank: ☐ No ☐ Yes
Photos: ☐ No ☐ Yes
EM: ☐ No ☐ Yes

Flow Cytometry: ☐ No ☐ Yes
Lymphoma Protocol: ☐ No ☐ Yes
Cytogenetics: ☐ No ☐ Yes
Other: _____