

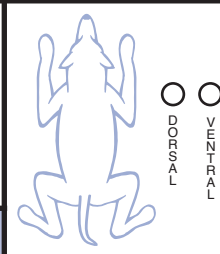


1-800-341-3440

Date	Owner																		
/ /	Pet Name																		
Doctor																			
Chart Number																			
<input type="radio"/> Canine	<input type="radio"/> Equine	<input type="radio"/> Ferret	Sex		Age	Breed													
<input type="radio"/> Feline	<input type="radio"/> Avian		<input type="radio"/> M	<input type="radio"/> MC															
<input type="radio"/> Other			<input type="radio"/> F	<input type="radio"/> FS															
Antech Pathologist																			

DOCTOR

<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>

Pathology	Cytology	Location
<input type="radio"/> <b>CFBX</b> Biopsy <input type="radio"/> <b>CSTAT</b> (for Biopsy only additional charge) <input type="radio"/> <b>CCBE</b> Surgical Margin Evaluation <input type="radio"/> <b>CDERM</b> Dermatopathology Consult (add'l form required, see Service Directory)	<input type="radio"/> <b>CCYTO</b> Cytology <input type="radio"/> <b>CFLUA</b> Fluid Analysis w/ Cytology <input type="radio"/> <b>CBONE</b> Bone Marrow Cytology <input type="radio"/> <b>CCSF</b> CSF w/ Cytology <input type="radio"/> <b>CPASC</b> Cytology w/PAS Stain	<input type="radio"/> <b>CAFS</b> Acid Fast Stain <input type="radio"/> <b>CGRAM</b> Gram Stain 

Specimen Description	Type of Biopsy
Surgical Excision: <input type="radio"/> Complete <input type="radio"/> Partial <input type="radio"/> Excisional <input type="radio"/> Wedge <input type="radio"/> Punch <input type="radio"/> Needle <input type="radio"/> Endoscopic <input type="radio"/> Surgical margins inked	
Items Submitted: # of containers. _____ # of specimens. _____ # of sites sampled. _____	

**Clinical History (Required Information)**

Source(s):	Previous diagnostic testing ref no. _____	Previous biopsy or cytology ref no. _____
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Please provide a concise clinical summary. Describe gross appearance, size and distribution of the lesion(s). Attach clinical diagnosis, photographs, radiographs, drawings, prior histopathologic or cytologic diagnosis where appropriate.

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**Specimen Processing** Lab use only

Number of Containers \_\_\_\_\_ Number of Cassettes \_\_\_\_\_ Technician \_\_\_\_\_

Container #	Bottle Label	Piece(s)	Sections(s)	Cassette #	Notes

62470

EAGLE (800) 266-6668

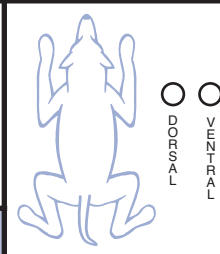


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<input type="radio"/> Other			<input type="radio"/> F	<input type="radio"/> FS					
Antech Pathologist									

DOCTOR

<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>

Pathology	Cytology	Location
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Specimen Description	Type of Biopsy
Surgical Excision: <input type="radio"/> Complete <input type="radio"/> Partial <input type="radio"/> Excisional <input type="radio"/> Wedge <input type="radio"/> Punch <input type="radio"/> Needle <input type="radio"/> Endoscopic <input type="radio"/> Surgical margins inked Items Submitted: # of containers. _____ # of specimens. _____ # of sites sampled. _____	

**Clinical History (Required Information)**

Source(s):	Previous diagnostic testing ref no. _____	Previous biopsy or cytology ref no. _____
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Number of Containers \_\_\_\_\_ Number of Cassettes \_\_\_\_\_ Technician \_\_\_\_\_

Container #	Bottle Label	Piece(s)	Sections(s)	Cassette #	Notes

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<input type="radio"/> Other			<input type="radio"/> F <input type="radio"/> FS		

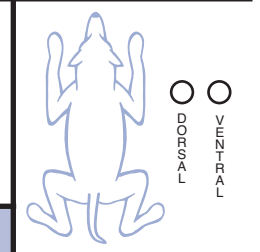
Antech Pathologist

DOCTOR

Pathology	Cytology	Location
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**CFBX** Biopsy  
 **CSTAT** (for Biopsy only additional charge)  
 **CCBE** Surgical Margin Evaluation  
 **CDERM** Dermatopathology Consult  
 (add'l form required, see Service Directory)

**CCYTO** Cytology  **CAFS** Acid Fast Stain  
 **CFLUA** Fluid Analysis w/ Cytology  **CGRAM** Gram Stain  
 **CBONE** Bone Marrow Cytology  
 **CCSF** CSF w/ Cytology  
 **CPASC** Cytology w/PAS Stain



Specimen Description	Type of Biopsy
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Surgical Excision:  Complete  Partial  Excisional  Wedge  Punch  Needle  Endoscopic  Surgical margins inked  
 Items Submitted: # of containers. \_\_\_\_\_ # of specimens. \_\_\_\_\_ # of sites sampled. \_\_\_\_\_

**Clinical History (Required Information)**

Source(s):	Previous diagnostic testing ref no. _____	Previous biopsy or cytology ref no. _____
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Please provide a concise clinical summary. Describe gross appearance, size and distribution of the lesion(s). Attach clinical diagnosis, photographs, radiographs, drawings, prior histopathologic or cytologic diagnosis where appropriate.

**Specimen Processing** Lab use only

Number of Containers \_\_\_\_\_ Number of Cassettes \_\_\_\_\_ Technician \_\_\_\_\_

Container #	Bottle Label	Piece(s)	Sections(s)	Cassette #	Notes

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