

TRANSCENDENT PATHOLOGY

1529 Residence Drive, Columbia, MO 65201
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☐ Send Specimen Containers?
Type Container _____
Quantity _____

Veterinarian _____
Clinic Name _____
Address _____
Phone (____) _____
Cell Phone (____) _____
Fax (____) _____

Account Number	
Patient Accession Number	
Date Received	
Date Reported	
Pathologist	
Referring Doctor	
Other Patient ID	

Patient _____
Owner _____
Address _____
Phone (____) _____
Fax (____) _____

Patient Information

Number of animals in this submission _____
Number of animals in affected group _____
Number of sick animals _____
Number of dead animals _____
Vet Clinic Patient Number _____
Animal name or Number _____
Species _____
Date animal died _____
Date animal submitted _____
Date specimen submitted _____

Specimen(s) submitted

Research Submission? Yes or No

Quantity

☐ Carcass
☐ Fixed Tissue Fixative: ☐ 10% NBF ☐ Bouin's ☐ Decal Soln ☐ Other
☐ Fresh Tissue
☐ Frozen Tissue
☐ Glass Slides
☐ Other

Description of tissue or specimen(s) _____

Test(s) Requested (check all that apply)

☐ Histopathology ☐ Microbiology ☐ Frozen Sections
☐ Cytology ☐ Parasitology ☐ Immunohistochemistry
☐ Necropsy ☐ Hematology
☐ Other ☐ Clinical Chemistry

Additional information about requested tests _____

Differential diagnosis _____

Brief history including symptoms, duration of illness, therapy, dietary history, management practices, etc.:

Description of gross lesions including location, size, color, consistency, distribution, pattern, etc.

(If tissue specimen, indicate the biopsy site on diagram by circle or "x.")

Previous case number (if applicable): _____
(Continue history or description on back if necessary.)

