

Date: _____

PetLABS, Inc.
Diagnostics Laboratories
Veterinary Surgical Pathology Services
96 Grace Drive Powell, Ohio 43065
Tel: (330)220-6435, Fax(330)220-1661
CyberOpBug@aol.com

Hospital Name: _____

Owner: _____

Veterinarian: _____

Animal ID: _____

Address: _____

Species/Breed: _____

City/State/Zip: _____

Age: _____ days, months, years

Phone: _____

Sex:(circle)

Male/Female

Fax: _____

Neutered/Intact

Email: _____

Pathologist preference (If available): _____

Total number of specimens: _____

Lesion duration: _____ days, weeks, months

Entire sample/lesion submitted: Yes No

Service Requested:

PLEASE NOTE:

WHEN SUBMITTING BONE, NAIL, CARTILAGE, TENDON, OR LIGAMENT,
PLEASE ADD 10 DAYS FOR PROCESSING AS THESE SUBMISSIONS MUST
BE SOFTENED (USING ACID) BEFORE CUTTING.

Histopathology

Joint Fluid Cytology

Bone Marrow

Endometrial Biopsy

Other: _____

Results: Mail Fax Phone Email

Specimens: Surgical Biopsy Necropsy Tissue Fluid Impression FNA Marrow

Sample

Location

Size(cm)

1.- _____

2.- _____

3.- _____

Lesion(s) description and clinical history: _____
