ALL CHILDREN'S HOSPITAL
Pathology and Laboratory Medicine
Outpatient Care Center - 4th Floor
601 5th Street South
St. Petersburg, Florida 33701

# Anatomic Pathology Requisition

Patient Name: ________________________________ Birth Date: ___________________
Date of Surgery: ________________________________
Pre-Op Diagnosis: ________________________________ Age: ________________________
Post-Op Diagnosis: ________________________________
Procedure: ________________________________ MRN: ________________________

Surgeon(s): ________________________________ Phone No.: ___________________

Hospital\Clinic: ________________________________

---

## Specimen & Biopsy Other Than Renal & Muscle/Nerve

The following information is required for all patients:

Site: ______________________________________________________________

Date of BX: ______________________Time of BX: ____________________________________

Additional Studies: No ____ Yes (results) ____________________________________

Genetic Study: No ____ Yes ____________________________________________

Enclose H&E Along With Pathology Report Of Tissue Or Tumor Specimens.

## Please Send Patient's History With Specimen

Submitted By: __________________________________ Phone No.: ___________________

Send Results To (Physician's Name & Fax No.): __________________________________