



APPLIED PATHOLOGY Biopsy Request Form

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Phone: 614-247-4795 Fax: 614-292-6473 Email: OSUAppPath@cvm.osu.edu

website: vet.osu.edu/biosciences/applied-pathology

Owner (Last, First): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Email (to send results): _____

Veterinarian/Surgeon: _____

Clinic/Hospital: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Email (to send results): _____

Signature: _____

Results will be available within 3 working days.

Animal name/ID#: _____

Species: _____ Breed: _____

Birth date: _____ Color: _____

Sex: Male Female Male/Castrated Female/Spayed Unknown

Clinical history (including PE/lab/biopsy/radiographic abnormalities):

Clinical diagnosis/differential diagnosis:

Operative procedure (excision, wedge, needle, etc):

Organ/exact location from which specimen(s) were removed:

Duration of lesion: _____

Size, color, consistency: _____

Special requests:

Number of containers: _____ Number of specimens: _____

Explicit description of margins if indicated (completed post-surgery):
