



FROZEN SECTION REQUISITION

Patient Name (Last)			(First)		
Age:		DOB:		Sex:	M / F
OR ROOM PHONE #		PHYSICIAN			
PREOP DIAGNOSIS / INFORMATION		CLINICAL			

PATHOLOGY CONSULTATION DURING SURGERY WITH FROZEN SECTIONS

DATE RECEIVED:

TIME:

AM

PM

GROSS DESCRIPTION

PREVIOUS BIOPSY

AT HMC

YES NO

OTHER FACILITY

YES NO

OPERATIVE DIAGNOSIS

FROZEN SECTION DIAGNOSIS

BENIGN

MALIGNANT

DEFERRED

COMMENT

NATURE OF SPECIMEN

DATE REPORTED:

TIME: AM

PM

PATHOLOGIST SIGNATURE

PATHOLOGIST SIGNATURE

PATHOLOGIST SIGNATURE

(PRINT)

(PRINT)

(PRINT)