NP/MGT/FM/011v6

SOUTHMEAD HOSPITAL BRISTOL
NEUROPATHOLOGY REQUEST FORM

Lab. Ref.

Please circle		Please circle
QUERY INFECTION RISK? YES (specify below) / NO	**Theatre**	**1 2 3 4 5 6 7 8 9 10**
HIV, TB, HEP B, HEP C	**Tel/Bleep Number:**	

SURNAME:	DoB:
FORENAME(S):	Male / Female
NHS number:	Consultant:
MRN Number:	Hospital:

EXAMINATION REQUIRED (please tick):

☐ Histology ☐ Intraoperative diagnosis ☐ Cytology (CSF) ☐ Post Mortem

Number of specimen pots to be sent: ……..

Specimen/specimen site: .....

……

CLINICAL HISTORY:

_____

_____

_____

Imaging appearances (circle): Circumscribed/Infiltrative; Enhancing/Non-enhancing;_____

Symptoms & Duration:_____

Clinical Differential Diagnosis:_____

Relevant treatment:_____

Other:_____

SPECIMEN COLLECTION DETAILS

Date and time taken: Collectors Signature:

---------- Print Name:

Tick box if tissue <u>taken for freezing</u> for Molecular Genetics ☐

Tick box if consent *<u>WITHHELD</u>* **to use specimen for education and research** ☐

Lab use only:

Any previous Biopsy: Yes / No: Biopsy No:

Date and time received: Received by: