SOUTHMEAD HOSPITAL
BRISTOL

Lab. Ref.

NEUROPATHOLOGY

REQUEST

Please circle

Theatre	**1 2 3 4** **5 6 7 8** **9 10**
Tel/Bleep No.	

Surname: .... DoB: ....M/F..........

Forenames :.. Hospital :................................

Consultant/G.P: .... Ward/O.P: ....

NHS number…………………………………………………………………..

MRN Number:

Examination required (please circle):

☐ Histology ☐ Intraoperative diagnosis ☐ Cytology ☐ Post Mortem

Specimen/specimen site:

....

....

Clinical History: (Please include symptoms and duration, imaging appearances, clinical differential diagnosis and relevant treatment).

....

....

....

Any previous Biopsy No.: (..

Date and time taken: .... Signature: ....

Date and time received: ………………………………………………………. Received by:…………………

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

Tick box if consent *WITHHELD* to use specimen for education and research ☐