ANIMAL DERMATOPATHOLOGY SERVICES

949-779-2996
dermatopathology@adcmg.com

HISTOPATHOLOGY REQUEST FORM

(949) 779-2996

M. Kelly Keating, DVM, DACVP, DACVD
Erica Noland, DVM, DACVP
Wayne Rosenkrantz, DVM, DACVD

SHIP SAMPLE(S) TO:

West Coast:
Pathwood Veterinary Laboratories
1415 NE 123rd St.
Seattle, WA 98125

East Coast:
Biosphere Lab (Attn: Dr. Biswell)
11700 Commonwealth Dr. Suite 200
Louisville, KY 40299

Send samples via trackable shipping service

HISTOPATHOLOGY TEST REQUEST

	Fee
☐ **Histopathology** (includes one of the following) • Dermatopathology: up to 4 punch biopsies (≤ 6 mm) in one formalin jar. Special stains included at no additional fee at the pathologist discretion. • 1-2 small masses (≤ 8 mm) in one formalin jar • 1 large mass (> 8 mm)	**$172**
☐ **Additional Tissue** Additional tissue charge including punch biopsies in separate jars or additional masses. *This is a per jar fee.*	**$45**
☐ **Second Opinion Interpretation** (send 1 stained and 4 unstained slides; or the FFPE block)	**$122**
☐ **Special Stain Request** (pre-ordered)	**$44.50/ea**
☐ PAS ☐ Acid- Fast ☐ GMS ☐ Other (s):_____	
☐ **IHC Stain** (if recommended by the pathologist)*	**$98 - 196**
☐ **PARR/Clonality** (if recommended by the pathologist)*	**$140 - 362**
☐ **Pathologist Requested** (optional)	
☐ Keating ☐ Noland ☐ Rosenkrantz ☐ No Preference	

Telephone consultation available upon request.

**IHC pricing varies based on outside laboratory stains, an estimate will be provided.*

*By submitting this sample, you acknowledge and consent that photographs or images of the biopsy may be used for educational, teaching, or research purposes, with all reasonable efforts made to maintain patient confidentiality. If you wish to **opt out**, please check this box.* ☐

ACCESSION NUMBER (FOR LAB USE ONLY) _____

TRACKING NUMBER _____

SUBMITTER INFORMATION

Referring Veterinarian: _____

Clinic: _____

Clinic Address: _____

Phone: _____

Email (for results): _____

Email (for invoicing, if different): _____

PATIENT INFORMATION

Client Last Name: _____

Patient Name: _____

Species: _____ Breed: _____

Sex: _____ Age: _____ Color: _____

Patient history included/attached? ☐ Yes ☐ No

Photos? (encouraged) ☐ Yes ☐ No

Digital records and photos can be emailed to dermatopathology@adcmg.com

CLINIC HISTORY

Please complete information below OR **attach last SOAP**

CLINICAL DIAGNOSIS: _____

Please check all that apply:

☐ Pruritus ☐ Symmetrical ☐ Erythema ☐ Vesicles ☐ Hypotrichosis ☐ Hyperpigmentation ☐ Macule ☐ Scale ☐ Scar ☐ Fissure ☐ Patch
☐ Papules ☐ Plaque ☐ Pustules ☐ Wheal ☐ Nodule ☐ Cyst ☐ Alopecia ☐ Crust ☐ Casts ☐ Comedo ☐ Depigmentation ☐ Ulcer
☐ Excoriation ☐ Erosion ☐ Lichenification ☐ Callus ☐ Epidermal collarette

Additional Information: _____

SAMPLE LOCATION:

Please describe location and not container number on ID chart and container

Container 1 (see below for multisite biopsies): _____

Site: _____

Site: _____

Site: _____

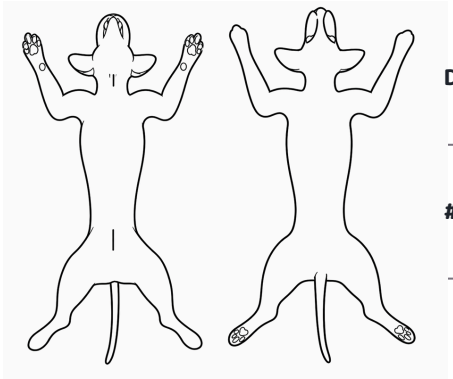
Site: _____

Container 2: _____

Container 3: _____

Container 4: _____

Additional Containers: _____



Date Specimen Taken: _____

# of Sites Submitted: _____