AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	TISSUE EXAMINATION

SPECIMEN SUBMITTED BY | DATE OBTAINED

SPECIMEN

BRIEF CLINICAL HISTORY *(Include duration of lesion and rapidity of growth, if a necoplasm)*

PREOPERATIVE DIAGNOSIS

OPERATIVE FINDINGS

POSTOPERATIVE DIAGNOSIS

SIGNATURE

NAME OF SIGNER

TITLE OF SIGNER

PATHOLOGICAL REPORT

NAME OF LABORATORY

ACCESSION NO(S).

GROSS DESCRIPTION, HISTOLOGIC EXAMINATION AND DIAGNOSES

SIGNATURE OF PATHOLOGIST | NAME OF PATHOLOGIST | DATE

HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT | DEPARTMENT/SERVICE OF PATIENT

RELATION TO SPONSOR | SPONSOR'S NAME *(Last, first, middle)* | SPONSOR'S ID NUMBER *(SSN or Other)*

PARIENT'S IDENTIFICATION *(For typed or written entries, give: Name--last, first, middle; ID no. (SSN or other); Sex; Date of Birth; Rank/Grade)* | REGISTER NO. | WARD NO.

TISSUE EXAMINATION

Medical Record

STANDARD FORM 515 (REV. 8-97)
Prescribed by GSA/ICMR FPMR 101-11.203(b)(10)