

Customer #: _____	Phone: _____	ID Animal: _____	DO NOT WRITE OR PASTE ANYTHING HERE - RESERVED SPACE BIOVET ORDER NUMBER		
Clinic: _____	Owner: _____				
Veterinarian: _____	Reference: _____				
Address: _____	Species: <input type="checkbox"/> Canine <input type="checkbox"/> Feline <input type="checkbox"/> Equine <input type="checkbox"/> Ferret				Age: _____
Email: _____	<input type="checkbox"/> Other (specify): _____				Breed: _____
<input type="checkbox"/> Follow up case - order #: _____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Neutered				

CYTOTOLOGY

Fluid analysis

- CFLUA Abdominal fluid
- CFLUA Thoracic fluid
- CFLUA Pericardial fluid
- CFLUA Synovial fluid
- CFLUA CSF
- CFLUA Cell count only
- CFLUA Fluid proteins only

Lavages

- CFLUA Nasal lavage
- CFLUA Tracheal lavage
- CFLUA BAL
- CBONE Bone Marrow

Mass/Organe

- CCYTO Aspiration
- CCYTO Impression

Mass dimensions: _____

Description of lesion:

- Raised Flat Pedunculated Colored
- Firm Smooth Ulcerated Circumscribed
- Infiltrative Attached Mobile
- Alopecic Painful Pruritic

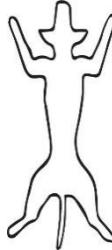
Duration and growth rate:

- Simple Multiple Solid Cystic

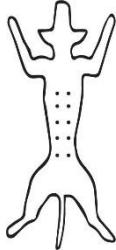
Site _____

Please make sure that all slides, tubes and/or containers are well identified with the owner's name and the origin of sample.

Mass or lesion location



Dorsal



Ventral

Date and time put in formalin: _____

DETAILED DESCRIPTION OF MASS / LESION

HISTOPATHOLOGY

- CFBX* Histopathology - 1 to 4 tissues (Companion animals and equine)
- CFBX5* Additional Tissue
- BVAD04 * Histopathology following a cytology (enter case number below) **

* Type of biopsy (REQUIRED)

- Excisional (margins present for evaluation)
- Incisional (no margin present for evaluation)
- Mammary chain (>3 glands)
- Whole Organ
- Endoscopic
- Needle
- Whole limb

Quantity of tissues submitted: _____

- CFBXNEO Cancer Pathology Service (Biopsy) (enter case number if applicable) **
- CFBXTBR Review - Cancer Tumor Board (Biopsy) (enter case number below) **

** Case number: _____

Type of sample submitted: _____

HISTORY

Treatment or vaccination:	Suspected condition:
Signature: _____	