

Specimen Transmittal Form Central Pathology Review



Patient identification			
DCOG patient ID	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Date of birth (dd/mm/yyyy)	__ / __ / ____
Patient initials	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> first name, surname	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female

Please send the original form with the slides to the reference pathologist.

See reference list per protocol

Please send a copy to SKION:

Trialbureau
Leyweg 299
2545 CJ The Hague

Pathology review information	
Hospital at diagnosis:
Treating physician:
Protocol:
Reference Pathologist:
Date biopsy:	__ / __ / ____ (dd/mm/yyyy)
Biopsy number(s):
Specimen type:
Working diagnosis: *
* Please include the complete report, including the immunophenotyping if available.	
Nr of pages in this shipment:	Nr of specimens in this shipment :

Remarks
.....
.....
.....

Contact Person			
Local Pathologist	<input type="text"/>	Phone #	<input type="text"/>
Date (dd/mm/yyyy)	__ / __ / ____		