



SAMPLE PATHOLOGY REPORT

Specimen and patient identification	
PATIENT: Patient Name	DATE OF BIRTH: 01/01/1960
MEDICAL RECORD NUMBER: Patient's hospital number	GENDER:
SPECIMEN COLLECTION DATE/TIME: 01/01/2019 12:00h	CASE NUMBER: Pathology case number
SPECIMEN RECEIPT DATE/TIME: 01/01/2019 13:00h	

SPECIMEN LABEL(S): Specimen site and medical procedure (such as "Appendix, appendectomy")

PATIENT HISTORY: Information the clinical team think the Pathologist should know about the patient, especially as it pertains to the specimen being evaluated.

PRE-OPERATIVE DIAGNOSIS: The current clinical diagnosis relating to the specimen. If the true diagnosis is not yet known, the clinical team may provide a list of possible diagnoses (a "differential diagnosis").

DIAGNOSIS:	The final diagnosis made by the Pathologist based on examination of the tissue specimen visually (grossly) and microscopically, and in combination with relevant clinical information.
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NOTE: The note (sometimes called comment) includes information that may be helpful to the clinical team. This could be a more detailed description of what the Pathologist saw in the specimen, an outline of other diagnoses that were considered, or information that can help with diagnosis and treatment.

SPECIAL TEST RESULTS: The pathology diagnosis may require extra testing such as special tissue stains. The results from this additional testing could be included here in the report.

GROSS DESCRIPTION: This is a description of the specimen when it was received by pathology. The description includes measurements (size and sometimes weight), markers of orientation, anatomic features and any pathologic findings that can be identified by sight or touch. The gross description also includes a list of all parts of the specimen that have been submitted for examination under the microscope.

NAME OR SIGNATURE OF PATHOLOGIST WHO COMPLETED REPORT
Date and Time Pathology Report Completed