Department of Pathology
Box 9203
1 Medical Center Drive
Morgantown, WV 26506
304-293-2092

Cilia Biopsy Clinical Data Sheet

DATE OF SPECIMEN COLLECTION:

PATIENT'S NAME: _____ DOB: _____ Gender: M F

MEDICAL RECORD NUMBER: _____

BIOPSY SITE: _____

CLINICAL HISTORY:

_____

_____

_____

CLINICAL DIFFERENTIAL:

_____

REQUESTING PATHOLOGIST OR CLINICIAN:

HOSPITAL/INSTITUTION:

ADDRESS:

PHONE NUMBER:

FAX NUMBER:

EMAIL ADDRESS: