Biopsy Approval

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Biopsy of : \_\_\_\_\_\_\_\_\_\_\_\_ in CT/ULS \_\_\_\_\_\_\_\_\_\_\_

Prior DX: \_\_\_\_\_\_\_\_\_\_\_\_\_

Prior Imaging \_\_\_\_\_\_\_\_\_\_

Requesting Dr:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved By: Faxed to Central:

 Date/Time: \_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Notes: |