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ANCILLARY DIVISION APPROVAL MATRIX		Section / Department **LABORATORY SECTION**
Policy Title: **POLICY ON HISTOPATHOLOGY TESTING**		Page **1** of **2**
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HISTOPATHOLOGY

NARRATIVE FLOW OF REQUEST FORM FOR HISTOPATHOLOGY TESTING

1. The attending physician prepares/accomplishes the Histopathology request form.

2. Duly accomplished request form and collected specimen with proper label and adequate amount of formalin MUST be submitted by a hospital staff together with the patient and/or relative to the laboratory.
3. The medical technologist screens requests for completeness of data and information and checks specimens for adequacy and appropriateness.
4. All payments shall be done at the Cashier Section. Charges are made according to the size of the specimen.
5. The medical technologist logs requests in the log book and assigns its corresponding accession number.

NOTE:

1. All requests for Histopathology testing MUST contain the following information: patient's name, date of request, type of specimen, patient's ward, attending physician's complete name with signature.

a) If the patient underwent a procedure (biopsy, PAP smear, etc) that will be greatly contributory to the present specimen and diagnosis, a photocopy of the result of the procedure and if possible, the actual slides, must be submitted.
b) The specimen should be placed in a wide-mouth container immersed in an adequate amount of 10% formalin (10-20x the assessed volume of the specimen). It should be submitted as soon as the procedure/operation is done.
c) . Fine needle aspiration biopsy smears must be fixed with 95% alcohol.

2. The medical technologist accepting the specimen and request should take note of the time the specimen was accepted and log the time in the request form.

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3. Acceptance of request and specimen is done daily, including weekends and holidays.

4. All official results are released within 14 working days from the time of receipt of specimen except for difficult cases that need to be passed around.

5. Results are made in triplicate copies. The first for the patient, the second to the health record and the third is left at this section for documentation and future reference 11