

RUN DATE:  
RUN TIME:  
BY:

**LABORATORY**  
Specimen Inquiry

PAGE:1

SPEC #:  
STATUS:

Obtained:  
Received:

Subm Dr:

**CLINICAL HISTORY:**  
ICD-180.9

**SPECIMEN/PROCEDURE:**  
1. CERVICAL BIOPSY

*ICD 0-3  
Carcinoma, squamous cell,  
large cell non keratinizing 8072/3  
Site Cervix NOS C53.9  
6/3/13*

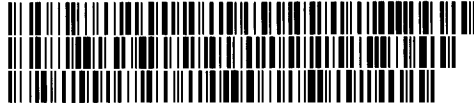
**IMPRESSION:**

**CERVIX, BIOPSY:**

- . Invasive squamous cell carcinoma, large cell nonkeratinizing type, moderately differentiated.
- . Extensive severe dysplasia.

UUID:5C7158E0-E120-4D7C-A68D-FA3853507A83  
TCGA-Q1-A6DW-01A-PR

Redacted



Dictated by:  
Entered:

**GROSS DESCRIPTION:**

1. Received in formalin labeled with the patient's name and cervical biopsy. Received are 3 pale pink to gray tan slightly hemorrhagic tissue fragments ranging from 0.4-1.4 cm in greatest dimension. The larger fragment be trisected perpendicular to the long axis. The specimen is entirely submitted in cassette 1A.

Dictated by:  
Entered:

**COPIES TO:**

Does Not Know

**CPT Codes:**

CERVICAL BIOPSY/88305

**ICD9 Codes:**

180.9

Resident Physician:

I have personally reviewed the material  
(specimen/slide) and approve this final report.

\*\* CONTINUED ON NEXT PAGE \*\*

Electronically Signed by: \_\_\_\_\_

Physicians

\*\* END OF REPORT \*\*

Criteria	Yes	No
Diagnosis Discrepancy		<input checked="" type="checkbox"/>
Primary Tumor Site Discrepancy		<input checked="" type="checkbox"/>
HIPAA Discrepancy		<input checked="" type="checkbox"/>
Prior Malignancy History		
Dual/Synchronous Primary		
Case is (circle):	QUALIFIED	DISQUALIFIED
Reviewer, Initials	BTH	Date Reviewed: 5/9/13