



Ship Samples to:
Sound VetPath
1146 Sea Vista Place
Edmonds, WA 98020

Client Name: _____

Case History (clinical signs, clinical lab data, imaging findings, description of gross lesions, treatment, etc)

Pet Name: _____

Patient ID
number: _____

Referring Vet Hospital and
phone: _____

Tentative Clinical Diagnosis:

Referring Veterinarian fax number:

Sample Sites/Locations

Ref Veterinarian Name and
email: _____

Number of Specimens
Evaluate Margins (Y/N)?

Species: _____

1. _____

Breed: _____

Sex: _____ Birthdate: _____

2. _____

Wild Caught (y/n) _____ Captive Bred
(y/n) _____

Check one: Biopsy Case _____
Autopsy Case _____ If Yes,
died/euthanized? _____

3. _____

Condition of body: _____

Total number of types of tissue _____

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Total number of cassettes _____

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