

Colorectal Cancer Surgical Pathology Requisition Form

SURGEON NAME: _____

DATE OF OPERATION: ____/____/____
DD/MM/YYYY

PATIENT ID INFORMATION

SPECIMEN SOURCE: **A:** _____

B: _____

C: _____

D: _____

HISTORY:

- | | | | |
|--|--------|---|---|
| <input type="checkbox"/> Malignant Polyp: | If so: | <input type="checkbox"/> Partial Removal | <input type="checkbox"/> Complete Removal |
| <input type="checkbox"/> Inflammatory Bowel Disease: | If so: | <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> Crohn's Disease |
| <input type="checkbox"/> Familial Polyposis: | Type | <input type="checkbox"/> FAP | <input type="checkbox"/> HNPCC |
| | | <input type="checkbox"/> Other _____ | |
- Other Relevant History (including related pathology)

NEOADJUVANT THERAPY:

- No Yes XRT: Short Course Long Course Chemo
 Unknown

CLINICAL STAGING (PRETREATMENT): cT _____ N _____ M _____

RADIOLOGY (for rectal tumors):

- Threatened CRM: No Yes Unknown
Suspected lymph node involvement No Yes Unknown
Suspected extramural venous invasion: No Yes Unknown

SURGICAL TECHNIQUE:

- Laparoscopic Open Transanal

PROCEDURE

- Colectomy:
 Left Total Abdominal
 Right Transverse
 Sigmoidectomy
 Anterior Resection
 Abdominoperineal Resection
 Total Proctocolectomy

For Rectal Procedures Only:

- Mesorectal Excision:
 Total Partial No

TUMOR SITE

- Single Multiple
- | | |
|--|--|
| <input type="checkbox"/> Cecum | <input type="checkbox"/> Rectum |
| <input type="checkbox"/> Right (Ascending) Colon | <input type="checkbox"/> Below peritoneal reflection |
| <input type="checkbox"/> Hepatic Flexure | <input type="checkbox"/> Anterior <input type="checkbox"/> Posterior |
| <input type="checkbox"/> Transverse Colon | <input type="checkbox"/> Above peritoneal reflection |
| <input type="checkbox"/> Splenic Flexure | <input type="checkbox"/> Anterior <input type="checkbox"/> Posterior |
| <input type="checkbox"/> Left (Descending) Colon | |
| <input type="checkbox"/> Sigmoid Colon | |
- Distance from anal verge: _____ cm

Other relevant intraoperative findings: _____

ORIENTATION OF SPECIMEN:

Suture Marking: _____ Proximal Margin _____ Distal Margin

Other Suture Marking (if necessary eg. soft tissue margin) _____