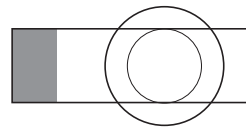


Krankenkasse bzw. Kostenträger		
Name, Vorname des Versicherten		
		geb. am
Kassen-Nr.	Versicherten-Nr.	Status
Betriebsstätten-Nr.	Arzt-Nr.	Datum



**Institut für Pathologie und Zytologie
Gemeinschaftspraxis**

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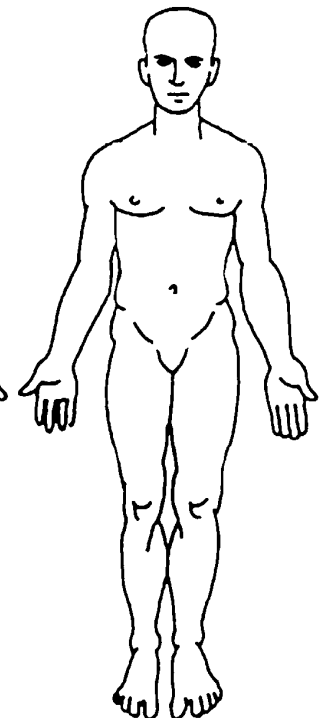
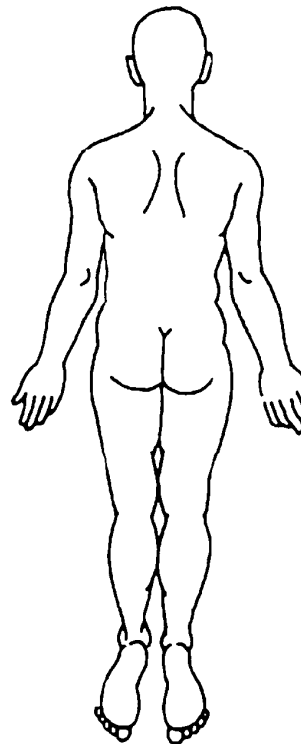
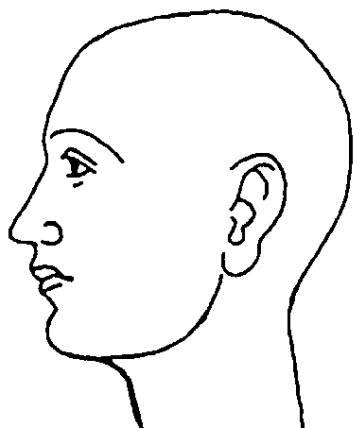
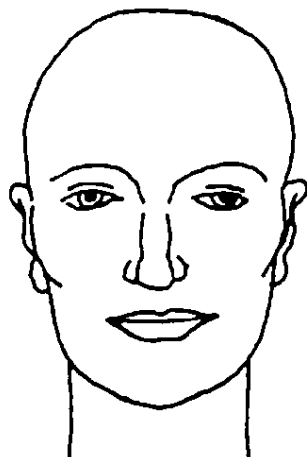
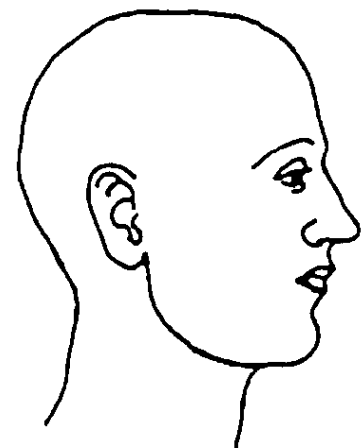
Diagnose/Verdachtsdiagnose

Total-
exzision Probe-
biopsie Shave/
Curettage Histograph.
Schnitttrand-
kontrolle

**BEGUTACHTUNGSANTRAG
HISTOLOGIE UND ZYTOLOGIE**

HKS

Arztstempel



Bitte Gewebe in ausreichend Formalin (4%) fixieren!