

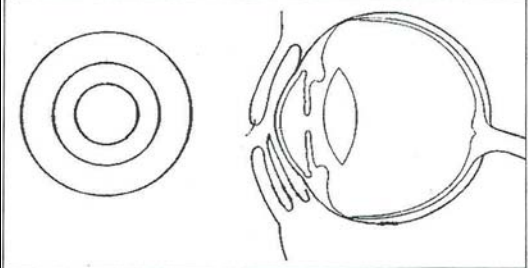
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**MAIL-IN OPHTHALMIC  
 SUBMISSION FORM**

Date Submitted:

Histopathology #:

Date Received:

|                                        |                                       |                                                                                      |      |
|----------------------------------------|---------------------------------------|--------------------------------------------------------------------------------------|------|
| Hospital:                              |                                       | Phone #:                                                                             |      |
| Veterinarian:                          |                                       | Fax #:                                                                               |      |
| Address:                               |                                       |                                                                                      |      |
| Tissue Submitted:                      | Owner:                                | Species:                                                                             | Sex: |
| Duration of Lesion:                    | Rate of Growth:                       | Breed:                                                                               | Age: |
| Circumscribed <input type="checkbox"/> | Infiltrative <input type="checkbox"/> |                                                                                      |      |
| Additional Description of Lesion:      |                                       |  |      |
| Clinical Diagnosis:                    |                                       |                                                                                      |      |
| History and Clinical Signs:            |                                       |                                                                                      |      |