REQUEST FOR MICROSCOPIC EXAMINATION ORAL PATHOLOGY

Rev 03.14.25

Diagnostic Laboratory
OHSU Department of Pathology
2730 S. Moody Ave Portland, OR 97201
MailCode: SD-PATH
Phone: 503-494-8904
Fax: 503-494-8905
Email: oralpath@ohsu.edu
(email photos/radiology here)
CLIA ID: 38D0713477

Biopsy Checklist
[ ] Label bottle with name and DOB
[ ] Obtain **MEDICAL INSURANCE i**nformation
[ ] Obtain patient address and phone
[ ] Email clinical/radiographic images (if desired) to oralpath@ohsu.edu
[ ] Complete all sections for thorough pathologic evaluation

CONTRIBUTING DOCTOR

Doctor Name: ______________________________

Street Address: ______________________________

____

City: ______________________ **State:** ___________

Zip Code___________________________________

Phone: ____________________________________

Fax: ______________________________________

PATIENT INFORMATION

Name: ___________________________________

DOB: ________________**Gender:** ___________

Street Address: __________________________

____

City: _____________________________________

State: _______ **Zip Code:** __________________

Phone: __________________________________

SURGERY INFORMATION

Date of Surgery: ____________________
Type:
[ ] Excisional
[ ] Incisional
[ ] Cytology

BILLING METHOD Select one.

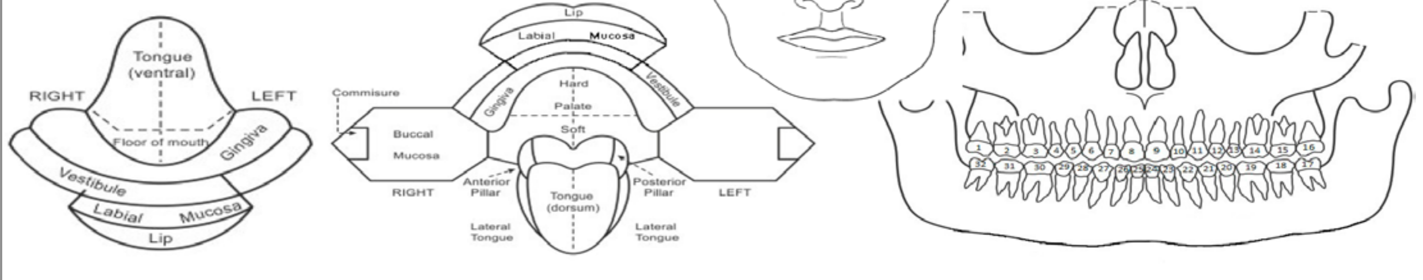
[ ] Patient Directly (no insurance)
[ ] Patient and Insurance
[ ] Doctor
[ ] Other: ______________________

Billing is done in accordance with the information provided and OHSU policy. Appropriate areas must be completed or ordering provider will be billed directly. ATTACH COPY OF MEDICAL INSURANCE CARD INCLUDING MEDICARE AND MEDICAID CARD (ON FULL PAGE) If not available please complete:

Medical Insurance Name: ____________________________ Policy Number: ________________ Group Number: ___________________________

Subscriber Name: ____________________________ Subscriber DOB_ _____________Patient Relationship to Subscriber: _________________

SPECIFY LOCATION:



CLINICAL DESCRIPTION AND HISTORY OF LESION (location, size, color, shape, radiographic findings):

HISTORY OF LESION (duration, rapidity of growth, variation in appearance, pain or other symptoms, probable causes, pertinent lab tests):

SIGNIFICANT PAST MEDICAL AND DENTAL HISTORY:

PROVISIONAL DIAGNOSIS:(ICD 10)

Send More Kits
Order Only if Needed.
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