REQUEST FOR MICROSCOPIC EXAMINATION ORAL PATHOLOGY

Rev 03.19.25

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
OHSU SOD CLINICS

DEPARTMENT: _____

ATTENDING:_____

RESIDENT:_____

PATIENT INFORMATION
AxiUm #:_____

Name: _____

DOB: _____**Gender:** _____

Street Address: _____

_____

City: _____

State: _____ **Zip Code:** _____

Phone: _____

SURGERY INFORMATION

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

BILLING METHOD Select one.

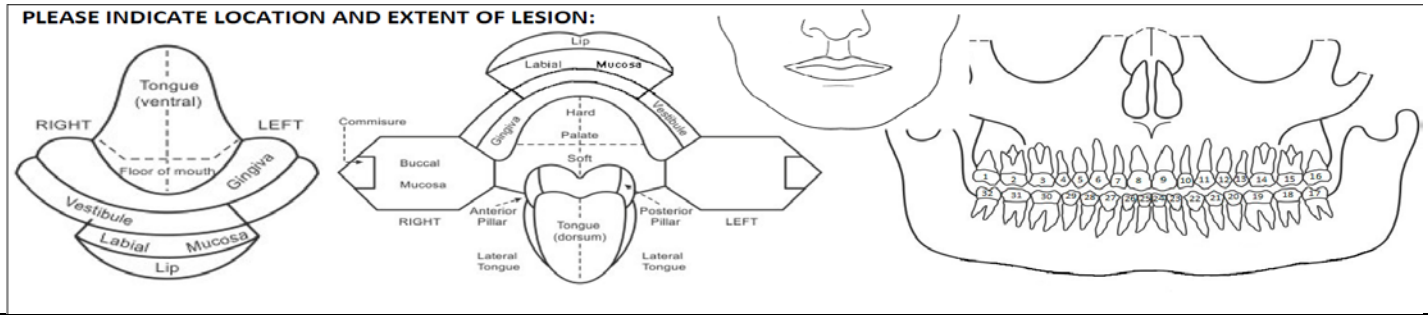
[ ] Patient Directly (no insurance)
[ ] Patient and Insurance
[ ] Doctor
[ ] Other: _____

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.
#_____