



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)

Biopsy Checklist

- Label bottle with name and DOB
- Obtain **MEDICAL INSURANCE** information
- 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: _____ Place of Service:
 Excisional Office
 Incisional Inpatient
 Cytology Outpatient Hospital

BILLING METHOD Select one.

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

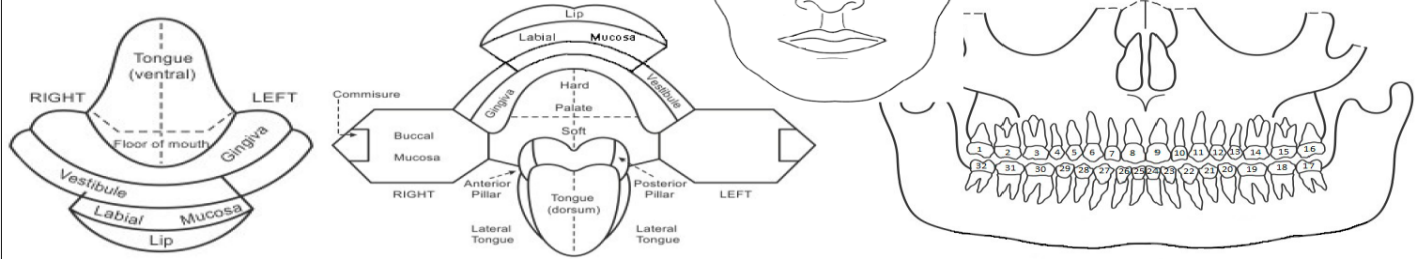
Billing is done in accordance with the information provided and OHSU policy. Appropriate areas must be completed or ordering provider will be billed directly. ATTACH COPY OF MEDICAL INSURANCE CARD INCLUDING MEDICARE AND MEDICAID CARD (ON FULL PAGE) If not available please complete:

Medical Insurance Name: _____ Policy Number: _____ Group Number: _____

Subscriber Name: _____ Subscriber DOB: _____ Patient Relationship to Subscriber: _____

SPECIFY LOCATION:

PLEASE INDICATE LOCATION AND EXTENT OF LESION:



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.
 # _____