

**REQUEST FOR MICROSCOPIC EXAMINATION ORAL PATHOLOGY**

Rev 03.25.26



**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](mailto: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

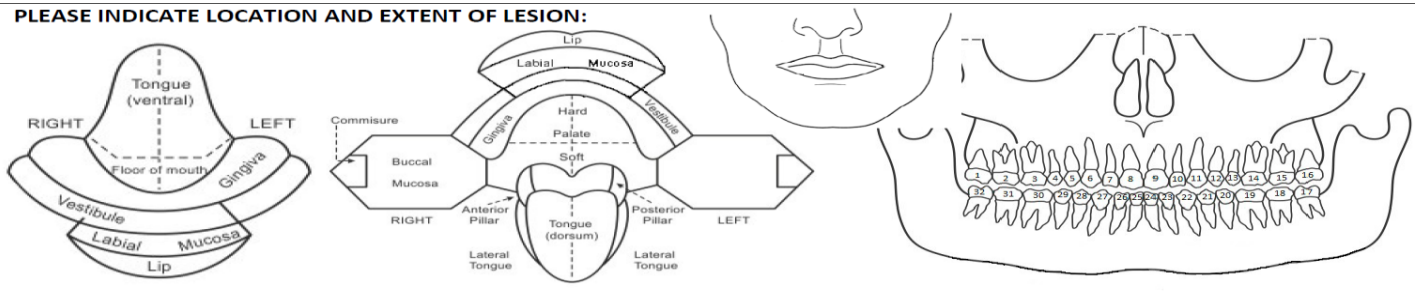
**BILLING METHOD** Select one.  
 Patient Directly (no insurance)  
 Patient and Insurance  
 Doctor  
 Other: \_\_\_\_\_

**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.  
 # \_\_\_\_\_