Request for Laboratory Study

LABORATORY USE ONLY

ORAL & MAXILLOFACIAL PATHOLOGY SERVICE – SCHOOL OF DENTISTRY
Box 357133 Seattle, WA 98195-7133 PH: 206-543-4440 FAX: 206-543-8054
EMAIL: **omps@uw.edu** **dental.washington.edu/oralpath**

***Please consult our referral email policy.**

Please include copies of the front and back of medical and dental insurance cards.
State law requires patient's name and date of birth on biopsy bottles.

Please select one of the following
- ☐ No Insurance
- ☐ Medical & Dental Attached
- ☐ Please Bill Doctor

→ **Date of Biopsy** (MM / DD / YYYY) _____

PATIENT INFORMATION – ALL SECTIONS BELOW ARE MANDATORY – PLEASE TYPE OR PRINT CLEARLY

Patient's Name (Last)	(First)	(Middle)	**DOB of Patient**	Sex ☐ Male ☐ Female	Ethnicity
If Minor, Parent or Guardian Name (Last)	(First)	(Middle)	**DOB of Parent/Guardian**	Social Security No.*	
Patient's Address (Number & Street) (Apt. #)					Home Phone
(City) (State) (ZIP)					Mobile Phone

PERFORMING DOCTOR INFORMATION

Doctor's Name (Last) (First) (M.I.)	Email and or Website	NPI No.
Doctor's Address (Number & Street)	(Suite #)	Phone
(City)	(State) (ZIP)	Fax No.

MEDICAL INFORMATION – Description of Lesion

Location

Size

Color

Symptoms

Associated Findings and Past History

Previous Biopsy Case No.

Smoking and Alcohol Use (optional)

Has the patient ever used tobacco products? ☐ Yes ☐ No

Number of years _____

Current use? ☐ Yes ☐ No

What type? ☐ Cigarette ☐ Pipe/Cigar ☐ Smokeless ☐ Beer ☐ Wine ☐ Other _____

Mouthwash (brand) _____

Toothpaste (brand) _____

PROCEDURE AND RESULTS

Radiographic Findings

Clinical Impression

Images (photographs/radiographs)
- ☐ Find Enclosed
- ☐ Images emailed to omps@uw.edu (*JPEGs are preferred*)
- ☐ Sent in separate envelope

Type of Biopsy ☐ Incisional ☐ Excisional ☐ Curettage ☐ Laser ☐ Other (specify) _____

* The Oral and Maxillofacial Pathology Service has requested your Social Security Number because it serves as a unique identifier. Disclosure of the number is voluntary and no statute or rule specifically directs the Service to request the number. If you decline to provide the number, the Service shall not for that reason deny diagnostic services.

Form Completed by _____

Performing Doctor's Signature **Doctor's Printed Name** Date

RESET FORM