

# Oral Pathology Consultants Laboratory Service Request Form

## Oral Pathology Consultants

## Pathologists

## Department use only

University of Maryland School of Dentistry  
 Department of Oncology and Diagnostic Sciences  
 650 W. Baltimore St., 7-North  
 Baltimore, MD 21201  
 Phone: 410-706-7936  
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 Email: oralpathologyconsultants@umaryland.edu  
 Web: <https://www.dental.umaryland.edu/oralpathology/>

John Basile DDS, DMSc  
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## Staff

Sue Hickson

Accession number:

Date received:

|                     |             |      |                |       |
|---------------------|-------------|------|----------------|-------|
| Patient information | Last name:  |      | First name:    |       |
|                     | SSN:        | DOB: | Gender:<br>M F | Race: |
|                     | Address:    |      |                |       |
|                     | City:       |      | State:         | Zip:  |
|                     | Home phone: |      | Work phone:    |       |

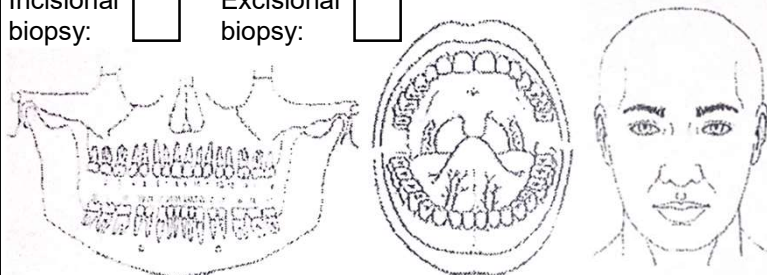
|                    |                |            |      |
|--------------------|----------------|------------|------|
| Doctor information | Doctor's name: |            |      |
|                    | Address:       |            |      |
|                    | City:          | State:     | Zip: |
|                    | Phone:         | Fax:       |      |
|                    | Email:         | Signature: |      |

|                   |   |                    |      |
|-------------------|---|--------------------|------|
| Medical insurance | <b>Please attach a copy of the patient's medical insurance card, front and back</b> |                    |      |
|                   | Insurance company address:  |                    |      |
|                   | City:   | State:             | Zip: |
|                   | Phone:  | ID number:         |      |
|                   | Policy holder:  | Membership number: |      |

|                 |                          |
|-----------------|--------------------------|
| Medical History | Smoking history:         |
|                 | Previous cancer history: |
|                 | Systemic diseases:       |
|                 | Medications:             |

Location of lesion: \_\_\_\_\_

Incisional biopsy:       Excisional biopsy:



Date of Surgery: \_\_\_\_\_

Description of lesion: \_\_\_\_\_

Size: \_\_\_\_\_ Color: \_\_\_\_\_

Shape: \_\_\_\_\_ Texture: \_\_\_\_\_

Radiographic appearance: \_\_\_\_\_

Cutaneous:     Intraoral:     Soft tissue:     Intra-osseous:

Radiograph provided:     Photograph provided:     Sent electronically:

Copy enclosed:

Clinical impression/Differential diagnosis: \_\_\_\_\_

|                         |                          |
|-------------------------|--------------------------|
| <b>Special requests</b> |                          |
| Written report only:    | <input type="checkbox"/> |
| Fax:                    | <input type="checkbox"/> |
| Request biopsy kits:    | <input type="checkbox"/> |

|                            |  |
|----------------------------|--|
| <b>Department use only</b> |  |
| Diagnostic code:           |  |
| Insurance code:            |  |



To order biopsy kits:

