DIAGNOSTIC PATHOLOGY REQUEST

ORAL & MAXILLOFACIAL PATHOLOGY, DIAGNOSTIC & CONSULTATIVE SERVICES
Augusta University, Dental College of Georgia
Department of Diagnostic Sciences
Augusta, GA 30912-1241
Tel: (706) 721-2721 Fax: (706) 721-4937

(PLEASE FILL OUT COMPLETELY)

For Office Use Only: ______________

Date of Biopsy: ______________

Lab No.: ______________________

Date Rec'd in Lab: ______________

PATIENT INFORMATION:

Patient's Name: ____
Last First MI

Mailing Address: ____

Phone: ______________________ **SSN/GDC#:** ______________________

Date of Birth: ____/____/____ (MO Day YR)

SEX: ☐M ☐F

AGE: __________

Race:
☐ Caucasian
☐ Black
☐ Asian
☐ Hispanic
☐ Other

BILLING: Please include copy of **Front & Back** of **MEDICAL** insurance card!

☐ Medicare
☐ Medicaid
☐ Private Ins.
☐ Self-Pay
☐ Bill Doctor
☐ Other

DOCTOR'S INFORMATION:

Doctor's Name: ____

Doctor's Address: ____

Phone: ______________ **Fax:** ______________ **Email:** ______________

Doctor's NPI#: ______________________

CLINICAL PRESENTATION

Clinical Features of the Lesion(s):

COLOR	TEXTURE	OTHER
☐ Black	☐ Rough	☐ Ulcerated
☐ Blue	☐ Smooth	☐ Soft
☐ Brown	☐ Circumscribed	☐ Firm
☐ Grey	☐ Diffuse	☐ Moveable
☐ Pink	☐ Raised	☐ Fixed
☐ Red	☐ Papillary	☐ Bleeding
☐ White	☐ Flat	☐ Exudate
☐ Yellow	☐ Indurated	☐ Vesicle

Was lesion associated with a tooth? ☐ Yes ☐ No

Size in mm:

Duration:

Site of Lesion:

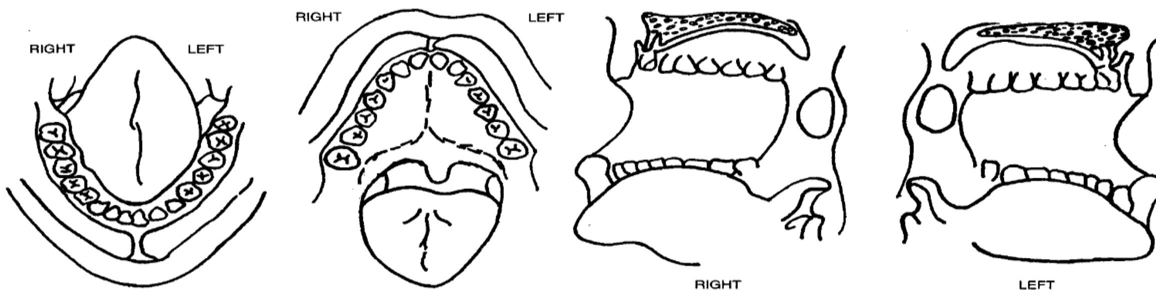
Tooth Vitality: ☐ Vital ☐ Non-Vital

Symptomatology:
☐ Asymptomatic
☐ Painful
☐ Tender
☐ Paraesthesia

Biopsy Procedure:
☐ Excision
☐ Incision
☐ Curettage
☐ Enucleation
☐ Apicoectomy
☐ Extraction
☐ Cytology

Radiographic Features:
☐ Opaque
☐ Lucent
☐ Solitary
☐ Multiiple
☐ Unilocular
☐ Multilocular
☐ Expansile
☐ Pericoronal

BIOPSY SITE:



ADDITIONAL CLINICAL FEATURES:

PERTINENT MEDICAL HISTORY & MEDICATIONS:

PROVISIONAL CLINICAL DIAGNOSIS:

Submitting Doctor's Signature:	**Date:**