30-XXXXX

ST. JOSEPH MERCY LABS

JVHL JOINT VENTURE HOSPITAL LABORATORIES

44405 WOODWARD, PONTIAC, MI 48341

Oral Pathology Consultants

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30-XXXXX PATIENT	30-XXXXX PATIENT	30-XXXXX PATIENT	30-XXXXX PATIENT
30-XXXXX PATIENT	30-XXXXX PATIENT	30-XXXXX PATIENT	30-XXXXX PATIENT

PATIENT INFORMATION

Patient Name (Last, First)

Patient Soc Sec # | ☐ Male ☐ Female | Date of birth (M/D/Y)

Street Address | Phone # ( )

City | State | Zip

Insurance ☐ No Insurance

Insurance ID#

Insurance GRP#

☐ STAT

☐ CALL RESULTS TO: _____

☐ FAX RESULTS TO: _____

Requesting Physician

Name: _____

Address: _____

Phone: _____

Fax: _____

I, the treating physician, order these tests for the diagnosis and treatment of this beneficiary, or for screening purposes.

Physician Signature Required _____ Date _____

Additional Copy of Report To:
Surgeon, Proceduralist and/or Primary Care Physician

Name: _____

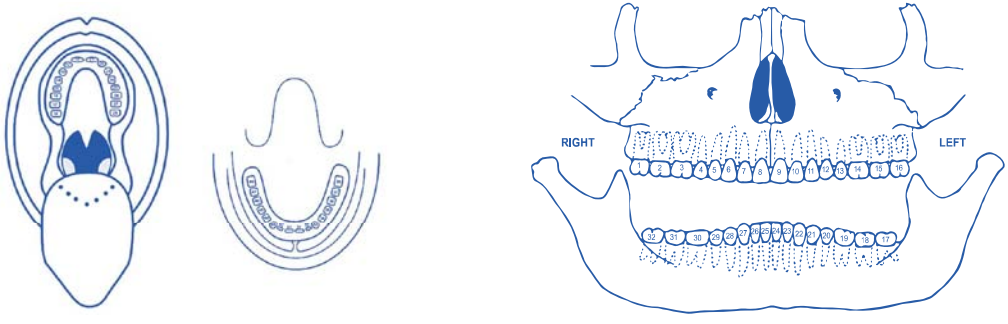
Address: _____ Fax: _____

SPECIMEN COLLECTED ON:

Date _____ **Time** _____

ORAL PATHOLOGY (TISSUES, CYTOLOGY) REQUEST

ICD-10 – AT LEAST ONE CODE IS REQUIRED



Findings and Gross Descriptions - Submit additional forms for additional specimens

Clinical Description of Lesion (Location, size, color, shape)

History - Lesion / Medical / Dental

Provisional Clinical Diagnosis

TYPE OF SPECIMEN:

☐ Excisional Biopsy ☐ Incisional Biopsy
☐ Curettage ☐ Apicoectomy
☐ Specimen for Immunofluorescence

MICROBIOLOGY

Source: _____ *Suscepitbility performed on potential pathogens

☐ Aerobic Culture* ☐ AFB Culture with Stain
☐ Anaerobic Culture ☐ Fungus Culture
☐ Gram Stain ☐ Other

Images (photographs/radiographs)

☐ Enclosed
☐ Emailed to mail@oralpathconsultants.com
☐ Sent in separate envelope

GLUE LINE

ORAL PATHOLOGY REQUEST