



UNIVERSITY OF WASHINGTON
**REQUEST FOR
 LABORATORY STUDY**
 ORAL & MAXILLOFACIAL PATHOLOGY SERVICE
 (206) 543-4440 omps@u.washington.edu

MAILING ADDRESS:
 Box 357133
 Seattle, WA 98195-7133

PHYSICAL ADDRESS:
 B-202 Health Sciences Center
 1959 NE Pacific Street

Medicare No.	
DSHS No. Enclose coupon	
<input type="checkbox"/> Please bill doctor	
<input type="checkbox"/> Please bill patient. Please enclose Front & Back copies of patient's MEDICAL/DENTAL and/or secondary insurance card if you want us to bill the patient's insurance directly.	

LABORATORY USE ONLY

Subscriber's Name _____

Subscriber's ID No. _____

Subscriber's Date of Birth _____

Date of Biopsy _____

am
 pm

INSURANCE Name and Address _____

PATIENT INFORMATION—PLEASE TYPE OR PRINT CLEARLY

Patient's Name (Last) _____ (First) _____ (M.I.) _____	Birthdate _____	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Race _____
If Minor, Parent or Guardian Name _____		Social Security No.* _____	
Patient's Address (Number & Street) _____ (Apt. #) _____		Home Phone _____	
(City) _____ (State) _____ (ZIP) _____	Work Phone _____		

REFERRING DOCTOR INFORMATION

Doctor's Name _____	UPIN No. _____
Doctor's Address (Number & Street) _____ (Suite #) _____	Phone _____
(City) _____ (State) _____ (ZIP) _____	Fax No. _____

MEDICAL INFORMATION

Description of Lesion (**PLEASE USE DIAGRAMS ON REVERSE SIDE**) _____

Location _____

Duration _____

Size _____

Color _____

Symptoms _____

Associated Findings and Past History _____

Previous Biopsy Accession No. _____

Smoking and Alcohol Use (optional)

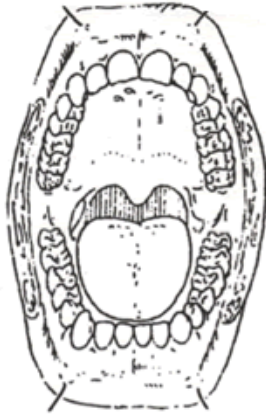
Has the patient ever used tobacco products? <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of years _____	Current use? <input type="checkbox"/> Yes <input type="checkbox"/> No	What type? <input type="checkbox"/> Cigarette <input type="checkbox"/> Pipe/Cigar <input type="checkbox"/> Smokeless	<input type="checkbox"/> Beer <input type="checkbox"/> Wine <input type="checkbox"/> Other _____	Mouthwash (brand) _____
					Toothpaste (brand) _____

PROCEDURE AND RESULTS

Radiographic Findings _____	<input type="checkbox"/> Radiographs Enclosed
Clinical Impression _____	<input type="checkbox"/> Radiographs Sent Separately <input type="checkbox"/> Photograph Enclosed
Type of Biopsy <input type="checkbox"/> Incisional <input type="checkbox"/> Excisional <input type="checkbox"/> Curettage <input type="checkbox"/> Laser <input type="checkbox"/> 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.

Requesting Doctor's Signature _____ Date _____



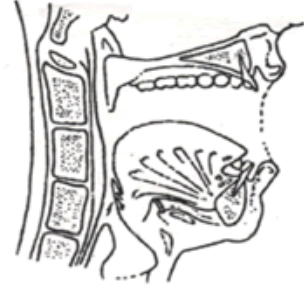
NORMAL



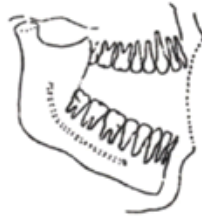
EDENTULOUS



RIGHT



LEFT



RIGHT



LEFT

