ORAL PATHOLOGY REQUISITION

APPLY ID STAMP OR STICKER HERE

9705 LENEXA DR, LENEXA, KS 66215
PH: (913) 396-8509 / (800) 933-6293 Fax: (816) 241-6531

CLIENT NAME AND ADDRESS	PATIENT NAME (LAST) (FIRST) (MI)			SEX	DOB
	COLLECTION DATE	PATIENT NUMBER	PATIENT SSN		

ORDERING PHYSICIAN

COPY REPORT TO:

CC REPORT TO

ADDRESS

CITY STATE ZIP

RESPONSIBLE PARTY & INSURANCE (ATTACH COPIES OF INSURANCE CARDS OR PATIENT DEMOGRAPHIC SHEET)

BILL TO ☐ PATIENT (SELF) ☐ INSURANCE

PT RELATIONSHIP TO INSURED ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

NAME OF INSURED (IF NOT SELF) | INSURED'S SSN:

ADDRESS CITY STATE ZIP

PHONE NUMBER HOME WORK

☐ **See Attached:**

Attach All Copies of Medical Insurance

CLINICAL INFORMATION

SPECIMEN NUMBER	BIOPSY SITE	CLINICAL DIAGNOSIS / ICD 10	SPECIMEN TYPE
A			☐ Incision ☐ Excision ☐ Shave ☐ Curettage
B			☐ Incision ☐ Excision ☐ Shave ☐ Curettage
C			☐ Incision ☐ Excision ☐ Shave ☐ Curettage
D			☐ Incision ☐ Excision ☐ Shave ☐ Curettage
E			☐ Incision ☐ Excision ☐ Shave ☐ Curettage

ADDITIONAL INFORMATION:

EMAIL RELEVANT PHOTOGRAPHS AND RADIOGRAPHS TO: oralpath@mawdpathology.com