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Print

UT Health San Antonio

Oral and Maxillofacial Pathology

LAB USE ONLY:

Accession #:

Date:

MSC 7750 7703 Floyd Curl Drive
San Antonio, TX 78229-3900

Anne C. Jones, D.D.S.
H. Stan McGuff, D.D.S.

Lab: 1888-PATH-211 (728-4211)
Phone: (210) 567-4073
FAX: (210) 567-6738

CLINICIAN INFORMATION (REQUIRED)

Clinician Name

Clinician Address

City/State/Zip | NPI #

Clinician Phone | Clinician FAX

Clinician E-Mail

PATIENT INFORMATION (REQUIRED)

Patient Name (Last, First, Middle) | Patient SS# | DOB (M/D/Y) | Race

Patient Address | City | State | Zip

Collection Date1 | Collection Time | Patient Phone | Gender ☐ M ☐ F

MEDICAL INSURANCE INFORMATION (REQUIRED) Attach copy of the Medical Insurance Card: Front & Back

Medical Insurance Company Name | Medical Insurance Company Address

Certificate Policy # | Authorization# | City | State | Zip

Group # | Insured's Name (Responsible party if patient under 18 *) | Insured's DOB (M/D/Y) *

MEDICARE/MEDICAID INSURANCE INFORMATION (REQUIRED) Attach copy of the Medical Insurance Card: Front & Back

Medicare #

Medicaid # | Insured's Name (Responsible party if patient under 18 *) | Insured's DOB (M/D/Y) *

Please bill: ☐ Patient ☐ Insurance ☐ Clinician

CLINICAL INFORMATION (See diagrams on reverse; if lesion involves bone, please enclose radiograph)

Exact Location of biopsy or surgical site

Duration

Symptoms

Color | Size (cm)

Specimen was: ☐ Excised ☐ Incisionally biopsied ☐ Smear ☐ Aspiration ☐ Other: _____

Additional/Pertinent History

☐ Microscopic Description Requested | ☐ Radiograph(s) Enclosed | ☐ Clinical Photographs(s) Enclosed

Clinical Diagnosis

LABORATORY USE ONLY

Time Specimen Received | Notes

Radiograph(s) Received ☐ Yes ☐ No | Clinical Photograph(s) Received ☐ Yes ☐ No

☐ Original request ☐ Additional request on this case

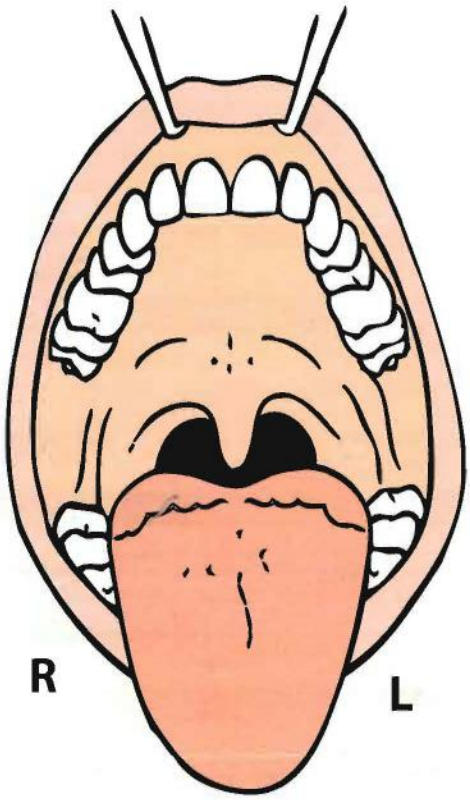
Tissue Source _____

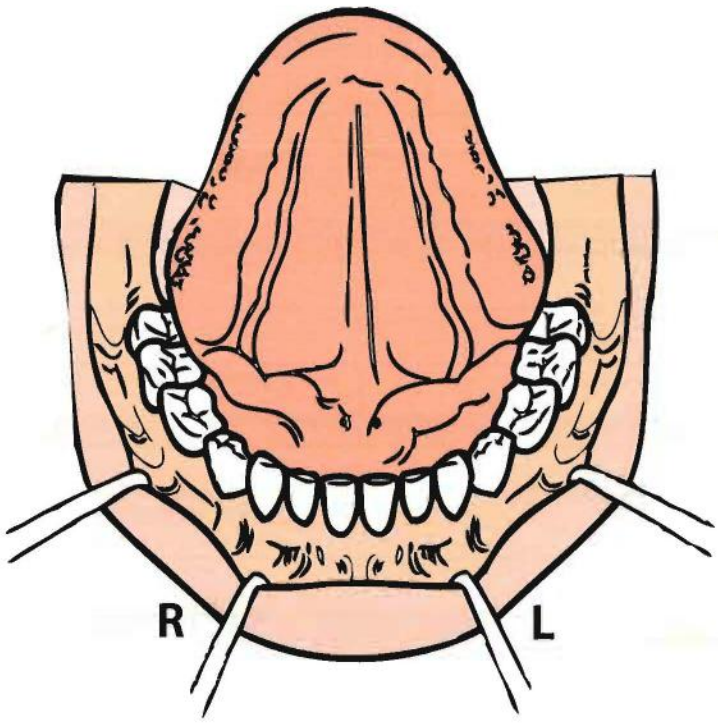
Client's Accession Number _____

Block Designation _____

MATERIALS SUBMITTED:	QUANTITY:	FIXATIVE:
☐ Blocks	_____	☐ Formalin
☐ Slides (Paraffin)	_____	☐ Michel's
☐ Slides (Frozen Sections)	_____	☐ None
☐ Smears	_____	☐ Other
☐ Other _____	_____	_____

MOUTH





RADIOGRAPH