

PATIENT DETAILS	REQUESTING CLINICIAN/ORGANISATION
Full Names: _____	Names: _____
Age: _____ <input type="checkbox"/> Years <input type="checkbox"/> Months Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Telephone Number: _____
Telephone Number: _____	Report to be sent to: (Email Address) _____
Date of Next Appointment: _____	

SPECIMEN INFORMATION	
Priority: <input type="checkbox"/> Routine <input type="checkbox"/> Urgent <input type="checkbox"/> Second opinion/Review	Type of Specimen:
Specimen Size/Complexity: <input type="checkbox"/> Small <input type="checkbox"/> Medium <input type="checkbox"/> Large <input type="checkbox"/> Complex resection	<input type="checkbox"/> Histopathology <input type="checkbox"/> Cytology/FNA <input type="checkbox"/> Soft tissue <input type="checkbox"/> Hard tissue/Bone <input type="checkbox"/> Both
Type of Biopsy: <input type="checkbox"/> Incisional <input type="checkbox"/> Excisional <input type="checkbox"/> Wide local excision <input type="checkbox"/> Cyst enucleation <input type="checkbox"/> If Other, specify : _____	Date of Specimen Collection: _____ Time: _____
	Fixation: <input type="checkbox"/> 10% Neutral buffered formation <input type="checkbox"/> Fresh/unfixed <input type="checkbox"/> Other, specify : _____

CLINICAL INFORMATION	
Anatomical site: _____	Size of the lesion: _____ X _____ X _____ mm
Laterality: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Anterior <input type="checkbox"/> Posterior <input type="checkbox"/> Midline <input type="checkbox"/> If Other, specify : _____	Duration: _____ (<input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years)
Description (Symptoms, appearance, color, consistency):	
Relevant medical/dental history: (Immune suppression, comorbidities, risk factors, tooth vitality)	
Pre-Operative Work up	<i>* All relevant imaging, clinical photographs and/or biopys results may be forwarded to info@theoralpathologyservice.com</i>
Imaging: <input type="checkbox"/> N <input type="checkbox"/> Y	
Key Findings:	
Previous Biopsy/FNA: <input type="checkbox"/> N <input type="checkbox"/> Y	
Diagnosis:	

Clinical Differential Diagnosis	Special Requests <i>(Special Stains, Immunohistochemistry, Margins)</i>

TO BE COMPLETED BY LABORATORY	
Specimen was: <input type="checkbox"/> Accepted <input type="checkbox"/> Rejected	Date Received:
Reason for Rejection:	Date Dispatched:
	Date Final Report Issued: