Oral Mucosal Biopsy Tracking Form

Patient name: _____ **Date of discovery:** _____

Medical insurance information carrier name: _____ **Group policy #:** _____

Carrier's address: _____ **Patient's Ins. ID #:** _____

Medical Insurance Anatomical Region Code

__Lip (#40490) __Tongue anterior 2/3 (#41100) __Tongue posterior 1/3 (#41105)

__Palate (42100) __Attached gingival (#41825) __Retromolar trigone (#41825)

__Buccal mucosa/Vestibule of mouth (#40808)

Preliminary ICD code: _____ **Lab confirmed ICD code:** _____

Clinical impression/Preliminary diagnosis: _____

Transepithelial (Brush) Biopsy

Brushing performed by: _____ **Date performed:** _____

Requested HPV test: Yes / No **Images sent to lab:** Yes / No

Lab name: _____ **Accession #** _____

Lab findings: _____ **Performed by:** _____

Date patient informed of results: _____ **Micrograph(s) received:** Yes / No

Lab's recommendations: _____

Surgical (Full Thickness) Biopsy

Biopsy performed by: _____ **Date performed:** _____

Biopsy method by: _____ **Type of biopsy:** Incisional / Excisional

Exam(s) requested: _____ **Fixative used:** _____

Sent previous report(s): Yes / No _____ **Image sent to lab:** Yes / No

Lab name: _____ **Accession #:** _____

Lab findings: _____ **Performed by:** _____

Additional tests recommended / performed: _____

Lab's recommendations: _____

Date patient informed of results: _____ **Micrograph(s) received:** Yes / No

Other Comments: _____

_____

_____

Completed By: _____

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