UCONN HEALTH

Oral Pathology Biopsy Service

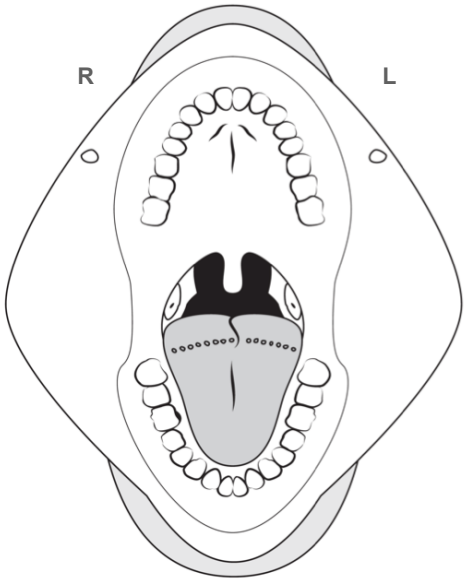
Request for Histologic Evaluation of Surgical Specimen

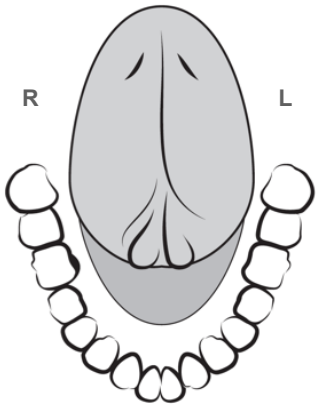
Please email related photos & radiographs to poreda@uchc.edu

Tel: (860) 679 3333
Fax: (860) 679 3765
Email: poreda@uchc.edu

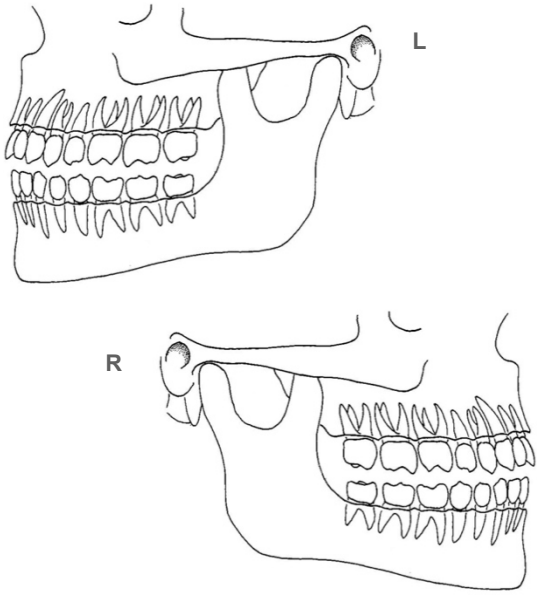
Patient Name (Last, First)		**D.O.B.**		**Age**		**Sex**	
Patient Address			**State**		**ZIP**		
Social Security #		**Tel.**					
Submitting Doctor's name		**Tel.**		**Fax**			
Submitter's Office Address			**State**		**ZIP**		
			Email:				
Date of Biopsy		**Specific Biopsy Site**					

SOFT TISSUE SPECIMEN





INTRAOSSEOUS SPECIMEN



HISTORY AND CLINICAL FINDINGS **(Please email related photos & radiographs to poreda@uchc.edu)**
(History, clinical data, lesion type, color, texture, radiographic features, Hx of previous biopsies)

Provider's Signature:

For UCONN OP Lab Use Only:
Pathologist's Dx, Micro, & Comments:

CLINICAL IMPRESSION/ DIFFERENTIAL DIAGNOSIS:

1.

2.

3.

MEDICAL INSURANCE INFORMATION (NOT DENTAL) (Please attach copies of patient medical insurance cards)			
MEDICARE ID # **Provider MUST be enrolled with PECOS**			
MEDICAID OF CT ID #			
PRIMARY INSURANCE NAME:		**Ins. ID #:**	
		D.O.B.	
SECONDARY INSURANCE NAME:		**Ins. ID #:**	
		D.O.B.	

UCONN HEALTH

School of Dental Medicine
Oral Pathology Biopsy Service
CLIA ID# 07D0945946

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Farmington, CT 06030
Telephone: 860 679 3333
Fax: 860 679 3765
Clinical consultations: 860 679 3170

PATIENT PLEASE NOTE

The tissue obtained today will be sent to the University of Connecticut Oral Pathology Biopsy Service for processing and microscopic examination by a Board-Certified Oral Pathologist. A separate fee is charged for this service in addition to fees charged by your doctor for the surgical procedure.

-- RELEASE OF INFORMATION --

I hereby authorize and direct my healthcare plan to pay University Physicians at UConn Health for analysis of my tissue. I authorize the release of any medical information pertaining to the examination of the specimen(s) that is necessary to process the insurance claim for this service. In the event that my insurance does not cover this fee, or if my insurance covers only a portion of the fee, I agree to accept full financial responsibility for payment of charges (or balance of charges) rendered to me.

Signature of Patient or Legal Representative Date