Oral Mucosal Biopsy Tracking Form

Patient Name: ______________________________________ **Date of Initial 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 gingiva (# 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 used: _______________________ **Type of biopsy**: Incisional / Excisional

Exam(s) requested: ________________________ **Fixative used**: ____________________

Sent previous report(s): Yes / No **Images 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: ____

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