Cleveland Clinic Laboratories

2119 E. 93rd / L15
Cleveland, OH 44106
216.444.5755 or 800.628.6816

ORAL AND MAXILLOFACIAL SURGICAL PATHOLOGY REQUISITION

<<FORM_ID>>

PATIENT INFORMATION (PLEASE PRINT IN BLACK INK)

Last Name | First | MI

Address | Birth Date | Sex ☐ M ☐ F

City | SS #

State | Zip | Home Phone

CLIENT INFORMATION

INSURANCE BILLING INFORMATION (PLEASE ATTACH CARD OR PRINT IN BLACK INK)

BILL TO: ☐ Office/Clinician ☐ Patient ☐ Demographic Sheet Attached ☐ Copy of Medical Insurance(s) Attached

INSURANCE NAME: _____

Subscriber Last Name | First | MI

Beneficiary / Member # | Group #

Claims Address | City | State | Zip

RESPONSIBLE PARTY: ☐ Patient ☐ Other (complete below)

Name

Address | City | State | Zip

ORDERING CLINICIAN

Clinician Name: _____

Clinician Phone: _____

Clinician Email: _____

Date of Service: ____/____/____

Collection Time: _____ ☐ a.m. ☐ p.m.

☐ Call results to phone number: (_____) _____

☐ Fax report to: (_____) _____

DIAGNOSIS CODE

ICD-10 Codes

1. _____
2. _____
3. _____

☐ Check if clinical/radiographic images sent to oralpath@ccf.org

☐ Excision
☐ Biopsy
☐ Curettage
☐ Apicoectomy
☐ Specimen for Direct Immunofluorescence

Biopsy Site(s):

Clinical Findings and History:

Size: _____

Color: _____

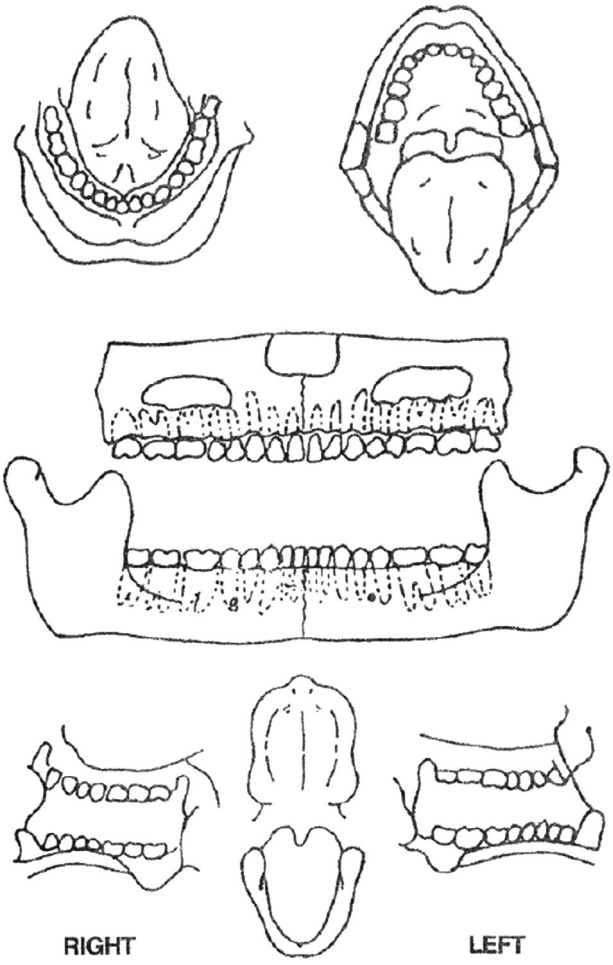
Radiographic Appearance: _____

Duration: _____

History/Other: _____

Clinical Impression:

Special Requests/Comments/Prior Pathology:



*CPT codes available online at clevelandcliniclabs.com 7/2023

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