

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: _____