



**Oral Pathology Consultants**

305 W 12<sup>th</sup> Ave. Columbus, OH 43210-1267

Phone (614) 292-6577 Fax (614) 292-9384

Patient Appointments: (614) 292-1472

Email: oralpathology@osu.edu

*John R. Kalmar, DMD, PhD, Lab Director*

*Susan R. Mallery, DDS, PhD*

*Kristin K. McNamara, DDS, MS*

**For lab use only:**

Date Received \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Patient ID No. \_\_\_\_\_

Accession No. \_\_\_\_\_

**Patient Information**

**First Name**

**M.I.**

**Last Name**

**Gender:** Male Female Other **Parent/Guardian (if patient is under 18):** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_ **Apt#:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Daytime Telephone Number:** (\_\_\_\_) \_\_\_\_\_ **home work cell (check one)**

**Date of Birth:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **PATIENT SSN:** \_\_\_\_\_

**Specimen Contributor Information**

**Dentist/Physician:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Telephone:** (\_\_\_\_) \_\_\_\_\_ **Fax:** (\_\_\_\_) \_\_\_\_\_

**NPI #:** \_\_\_\_\_

**Office Email:**

**Check for additional supplies or call (614)-292-6575:**

Biopsy kit(s)  
(package of 6)

Michel's Solution  
(individual quantity)

Cytology kit(s)  
(individual quantity)

UPS  
(labels and bags)

<b>Clinical Presentation:</b> (use diagram on opposite page)		<b>Radiographic Features:</b>	
Location: _____		Radiolucent	
Size: _____		Radiopaque	
<b>Color:</b>	<b>Shape:</b>	<b>Texture:</b>	<b>Consistency:</b>
Normal	Pedunculated	Smooth	Firm
White	Sessile	Granular/Rough	Soft
Red	Flat	Papillary	Fluctuant
Blue	Ulcerated	Pulsatile	Poorly-Defined
<b>Clinical/Social History:</b>		<b>Pertinent Medical History:</b>	
Tobacco Alcohol			
<b>Previous OSU Biopsy(ies) Accession #(s)</b>			
<b>Procedure:</b>	Excisional Biopsy	Incisional Biopsy	Cytology
<b>Operative Findings/Comments:</b>			
<b>Clinical Impression/Diagnosis:</b>			
<b>Additional Material(s):</b> <i>Radiographs are requested for skeletal lesions/specimens</i>			
Radiograph(s)	Emailed	Available	
Clinical image(s)	Emailed	Available	
Disc/thumb drive/other	Email address: oralpathology@osu.edu		
<b>Specimen Contributor's Signature:</b> _____			
<b>Date of Procedure:</b> ____/____/____			

