ORAL REQUISITION

CTA PATHOLOGY
CURTIS THOMPSON, MD & ASSOCIATES

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www.ctapathology.com

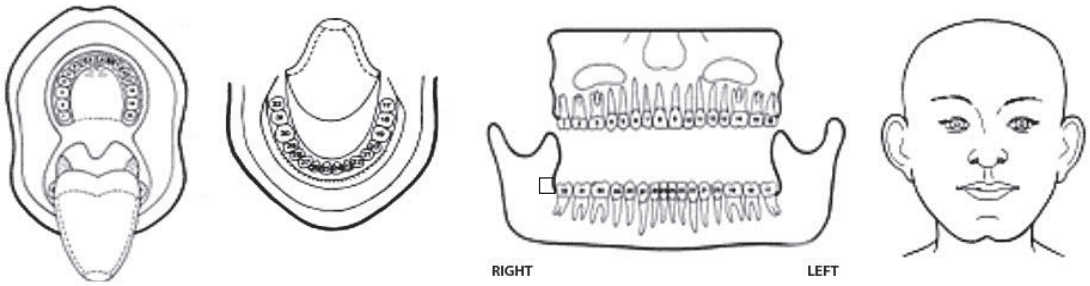
Submitting Physician (Name and Telephone)	**Today's Date**	**Date of Collection** *(Required)*

Patient Name (Last, First, MI) *(fill in or attach information)*	**Patient Date of Birth** *(Required)*	**Sex** ☐ **M** ☐ **F**
Patient Address (mailing: street, or box, city, state, ZIP)		**Patient Telephone**

Bill To: ☐ Insurance ☐ Medicare ☐ Medicaid/OMAP ☐ Patient ☐ Physician *(fill in or attach information)*

Primary Insurance:	**Secondary Insurance:**
Policy Holder's Name	Policy Holder's Name
ID/Group Numbers	ID/Group Numbers
Billing Address	Billing Address

Indicate Location and Extent of Lesion



Specimen Data

Specimen Type

☐ Excisional Biopsy ☐ Incisional Biopsy
☐ Cytology ☐ Immunofluorescence

Images

☐ Images emailed to oral@ctapathology.com

☐ Enclosed

☐ X-rays - _____ # enclosed

☐ Photos - _____ # enclosed

Specimen Site

Findings and Gross Descriptions - Submit additional forms for additional specimens

Clinical Description of Lesion (Location, size, color, shape)

History - Lesion / Medical / Dental

Provisional Clinical Diagnosis

Submitting Clinician Signature

Gross (Lab use only)

Specimen Color: ☐ *Tan* ☐ *Gray* ☐ *Brown* ☐ *Other:* _____ ☐ *Inked* ☐ *Sectioned*

Submitted: ☐ *Entirely* ☐ *Partially* _____ *x* _____ *x* _____ *mm*