ORAL REQUISITION

CTA PATHOLOGY
CURTIS THOMPSON, MD & ASSOCIATES

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

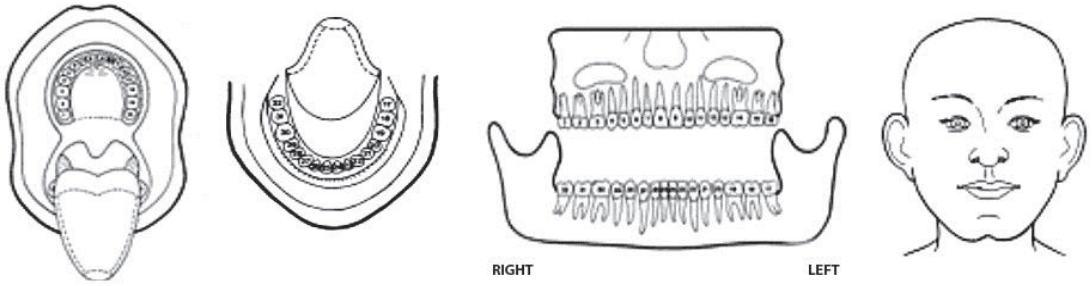
Office Address/Location *(Street, City, State, ZIP, Required)*

Patient Name *(Last, First, MI, Required)* *(fill in or attach information)*	**Patient Date of Birth** *(Required)*	**Sex** *(Required)* **M F**
Patient Mailing Address (Street/Box, City, State, ZIP, *Required*)		**Patient Telephone** *(Required)*

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
☐ Curettage ☐ 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*