Oral and Maxillofacial Histopathology Service

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Dr. Steve Tremblay

www.oralpathology.ca

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File number (reserved)

HISTOPATHOLOGY EXAMINATION REQUEST

Date of reception (reserved)

Patient Information

Last Name: _____ | First Name: _____
Sex (Please circle): Male / Female

Birth date (dd/mm/yyyy): ____ / ____ / _____

Dentist Information

Last Name: _____ | First Name: _____
Licence number: _____
Clinics: _____
Address: _____
_____
Phone: (____) _____-_____
Fax*: (____) _____-_____
Email: _____

Incisional biopsy ☐ Excisional biopsy ☐ Fine needle biopsy ☐ Smear ☐ DIF (Michel's) ☐

Radiographs: None ☐ Original ☐ Duplicata ☐

Details: _____
_____

Date of biopsy (dd/mm/yyyy): ____ / ____ / _____

Biopsy Site: _____
_____
_____

Clinical Information: _____
_____
_____

Differential diagnosis: _____
_____

Signature: _____ Date: ___ / ___ / _____

* The fax number will be used to send reports. Please don't forget it!

Please take note that we are not responsible for the transport of the specimens. Fees paid by the histopathology service are those for regular mail by an agreement with Canada Post. Dentists wishing to ship their specimens by registered mail must assume the expenses.