Fabien Baksh, MD, FCAP
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PSP USE ONLY:

ORAL / MAXILLOFACIAL REQUEST FORM

PATIENT INFORMATION

Last First M

SSN

Date of Birth Sex (circle one) M F

Address

City, State ZIP

Phone

PHYSICIAN INFORMATION

Date

Office site

Ordering physician

Copies to

Physician Signature

Label specimens with patient info and tissue type submitted and place in bio-bag

☐ **Bill Insurance** Please attach photocopy of patient's Insurance card ☐ **Self pay** ☐ **Client bill**

PATHOLOGY SPECIMEN/ICD-10

1.

2.

3.

4.

5.

6.

ADDITIONAL TESTS

Please specify specimen

- ☐ **Immunofluorescence (Michel's Medium)**
- ☐ **Aerobic Culture and Sensitivity**
- ☐ **Anaerobic Culture and Sensitivity**
- ☐ **Stone Chemical Analysis**
- ☐ **Other** _____

CLINICAL HISTORY

If Medicare, Submit ABN

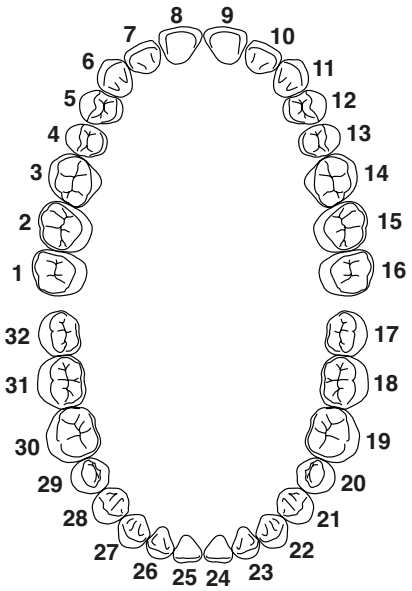
Check All That Apply

☐ Solid ☐ Cystic ☐ Mixed
☐ Radiolucent ☐ Radio-opaque ☐ Mixed

Tooth Association

☐ Apex ☐ Lateral border
☐ Crown/Root junction ☐ Other _____

☐ Vital ☐ Non-vital
☐ Extraction Site
☐ Erupted ☐ Impacted



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