DIAGNOSTIC PATHOLOGY MEDICAL GROUP, INC

ORAL PATHOLOGY CONSULTATION REQUEST

CAP ACCREDITED

Clinician name and address:

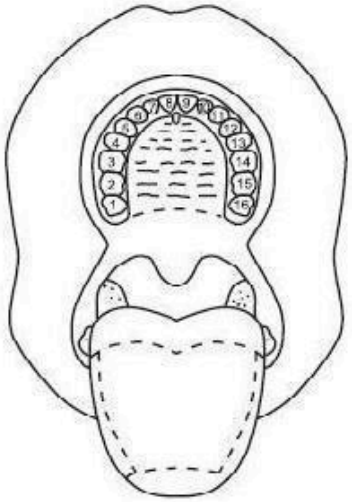
Customer Service and Courier Pickup
916-446-0424; Toll-free 800-464-0424
FAX 916-446-9330 www.dpmginc.com

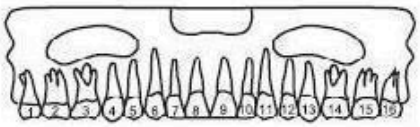
3301 C Street, #200E, Sacramento, CA 95816

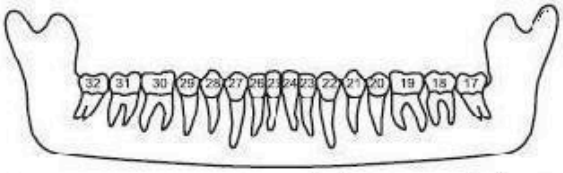
Additional Copies of Report To (Name and Address): _____

Required Fields - Please fill out all information in box. Thank you.

Patient Name: Last, First			Date Biopsy Taken
Patient Address	City	Zip Code	Telephone Number
Date of Birth	Age	Sex	Social Security Number







RADIOGRAPHIC APPEARANCE: _____

CLINICAL IMPRESSION/DIAGNOSIS: _____

Prior tissue reports? ☐ Yes ☐ No
Indicate accession # _____ Attach report if available.
***ICD-9 Diagnosis Code** (Required for all specimen referrals):* _____

INSURANCE ☐ Copy of insurance card(s) attached ☐ Cash Pay

Patient full name required - Place completed specimen label sticker on each container

Name (Last/First) _____	Name (Last/First) _____	Name (Last/First) _____
Date _____ Specimen _____	Date _____ Specimen _____	Date _____ Specimen _____
O00000001-1	O00000001-2	O00000001-3

O00000001