



DIAGNOSTIC
PATHOLOGY
MEDICAL
GROUP INC.

ORAL PATHOLOGY CONSULTATION REQUEST



Customer Service and Courier Pickup

916-446-0424; Toll-free 800-464-0424

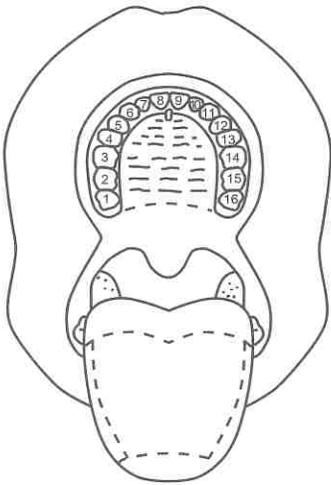
FAX 916-446-9330 www.dpmginc.com

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

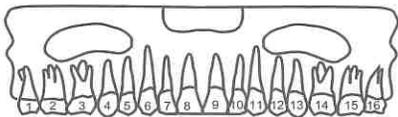
Additional Copies of Report To (Name and Address): _____

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

Patient Name: Last, First		Date Biopsy Taken	
Patient Address		City	Zip Code
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-10 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 _____
O00006170-1	O00006170-2	O00006170-3

O00006170