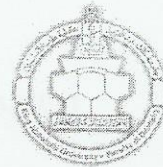
KINGDOM OF SAUDI ARABIA

Ministry of Higher Education

KING ABDULAZIZ UNIVERSITY

FACULTY OF DENTISTRY

University Dental Hospital



المملكة العربية السعودية

وزارة التعليم العالي

جامعة الملك عبد العزيز

كلية طب الأسنان

مستشفى الأسنان الجامعي

ORAL & MAXILLOFACIAL PATHOLOGY & DIAGNOSTIC LABORATORY

BIOPSY REQUEST FORM

File No: ______________________

Patient's Name: ____ **Age/Gender:** __________

Clinician's Name: ____ **Phone#:** __________________

Department: ____________________________________

Purpose of Biopsy: ____

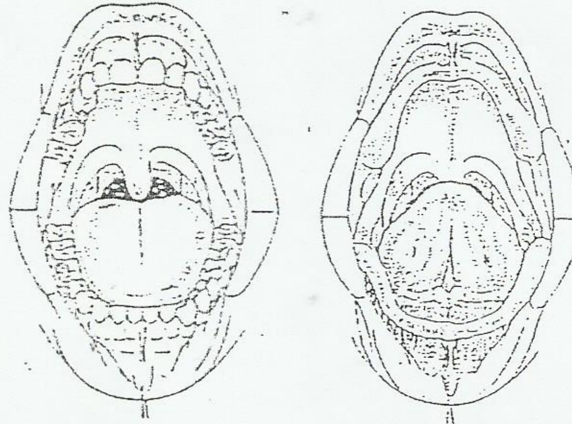
Clinical Information:

Does the specimen contain hard tissue: *Please check where appropriate:* **Yes:** ____ **No:** _____

Type of Biopsy: *Please check where appropriate*: **Incisional** ___ **Excisional** ____

Site of Biopsy: ____

Please mark the location with approximate lesion size:



Lesion's clinical description:

Relevant clinical history/information:

Radiographic findings: *Please describe relevant radiographic findings.*

Comments:

Clinical diagnosis: ____

Signature: ____________________________ **Date:** ______________________