KINGDOM OF SAUDI ARABIA
Ministry of Education
KING ABDULAZIZ UNIVERSITY
FACULTY OF DENTISTRY
University Dental Hospital

المملكة العربية السعودية
وزارة التعليم
جامعة الملك عبد العزيز
كلية طب الأسنان
مستشفى الأسنان الجامعي

ORAL PATHOLOGY CENTRAL LABORATORY
BIOPSY REQUEST FORM

Lab Number:

Date Received:

Private: ☐ **Routine:** ☐

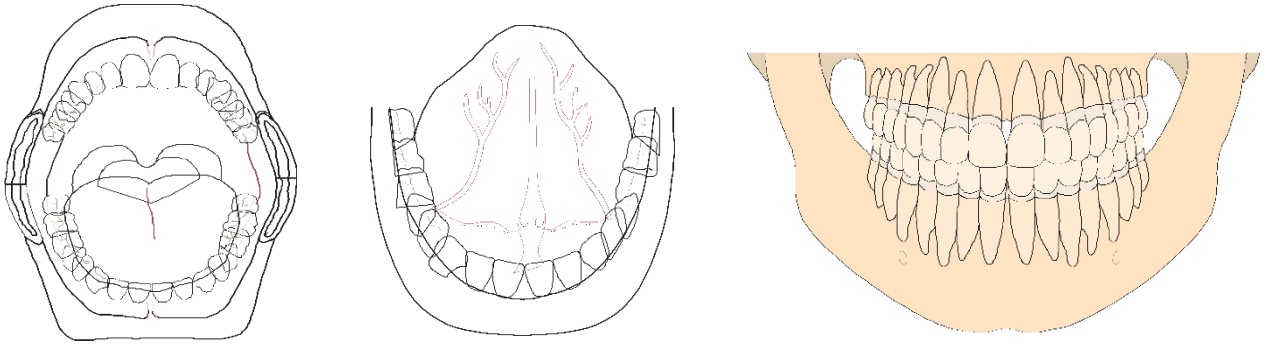
Patient's Name:.....**Clinician's Name:**.....

UDH File / ID number:.....**Clinician's Phone:**.....

DOB:..... **Age/Gender:**..... **Department/Clinic:**.....

Biopsy Type: **Incisional**..... **Excisional**..... **Cytology**.....

Site of Biopsy:.....



Clinical Features:

Presentation: .....

Color:..... **Consistency:** .....

Number of Lesions: .....

Associated Symptoms:.....

Duration:..... **Size of Lesion:** .....

Lymph Node Involvement: **YES.** ☐ **NO.** ☐

Relevant Clinical History: .....

Relevant Radiographic Findings:.....

Type of Radiograph: .....

Is There Any Advanced Imaging? **YES.** ☐ **NO.** ☐

Clinical Diagnosis: .....

Consultant's Name: .....

Signature:..... **Date:**.....

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