UNIVERSITY OF TORONTO
FACULTY OF DENTISTRY

TORONTO ORAL PATHOLOGY SERVICE

FOR SECURITY REASONS, THIS FORM DOES NOT STORE ANY INFORMATION

PLEASE TYPE IN ALL THE REQUIRED FIELDS AND INCLUDE A PRINTED COPY OF THIS FORM WITH THE SUBMITTED SPECIMEN

Lab number Internal use only

Biopsy date (dd/mm/yyyy)

Patient name

Gender

DOB (dd/mm/yyyy)

Smoker?

Health Card

Submitting Doctor

Name

Specialty

Address

Phone

Fax

Email Address

Location of lesion

Appearance/History (Size, shape, color, ulceration, duration, radiographs submitted?)

Clinical Diagnosis

Type of biopsy

Radiographs submitted

Clinical Photos submitted

Please submit radiographs and clinical photos to:
ORAL.PATHOLOGY@DENTISTRY.UTORONTO.CA
In order to protect patient information, please include only patient initials, submitting doctor information and date of biopsy in the email

Signature

124 EDWARD STREET, ROOM 314, TORONTO, ONTARIO M5G 1G6
Report & Biopsy Kit Enquiries –416-864-8243; Other Business – 416-864-8244; Fax: 416 979 4938