COPMD®
CENTRE FOR ORAL PATHOLOGY & MAXILLOFACIAL DIAGNOSTICS

Dr. Bhuvan Nagpal
MDS (Oral & Maxillofacial Pathology)
Founder & Director | Oral & Maxillofacial Pathologist

CENTRE FOR ORAL PATHOLOGY & MAXILLOFACIAL DIAGNOSTICS
1021, Urban Estate II, Hisar, Haryana - 125001
+91 98960 37444 | copmdhisar@gmail.com | www.copmd.in

BIOPSY EXAMINATION REQUEST

Please complete legibly. Match patient and specimen identifiers on every container and page.

01 PATIENT DETAILS

Full name: _____

Age / DOB: _____ Sex: _____ Patient ID: _____

Phone: _____ Guardian / relationship: _____

Address: _____

02 REFERRING CLINICIAN / INSTITUTION

Doctor: _____ Registration no.: _____

Clinic / hospital: _____

Phone: _____ Email: _____

03 SPECIMEN & COLLECTION DETAILS

Site / side / tooth number: _____

☐ Incisional ☐ Excisional ☐ Curettage ☐ Other: _____

Biopsy date / time: _____ Fixation date / time: _____

Fixative / medium: _____ No. of containers: _____

Container IDs / contents: _____

04 CLINICAL & RADIOGRAPHIC INFORMATION

Duration / symptoms / relevant history: _____

_____

Clinical appearance / size: _____

Radiographic findings: _____

Provisional diagnosis / differential: _____

Prior biopsy / treatment / relevant habits: _____

Referring clinician signature / stamp: _____ Date: _____

Attach clinical photographs, radiographs and previous reports where available. See pages 2 and 3.

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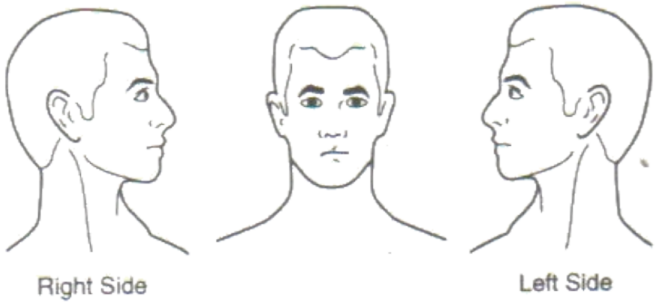
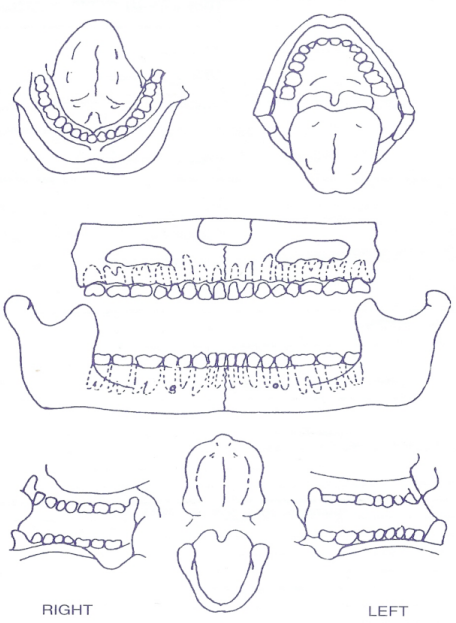
SITE MAPPING & LABORATORY RECORD

Mark each lesion and identify the corresponding container. Specify patient right / left.

Patient name: _____ Patient ID: _____





Site / container correlation and orientation: _____

_____

05 LABORATORY USE ONLY

Accession no.: _____ Received date / time: _____

Received by: _____ No. of containers: _____

☐ Radiographs ☐ Clinical photographs ☐ Previous reports ☐ Consent

Condition / discrepancy / action taken: _____

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CONSENT FOR TISSUE EXAMINATION

To accompany the requisition. This does not replace consent for the biopsy procedure.

Patient name: _____ Age / Patient ID: _____

Referring doctor / clinic: _____

06 PATIENT INFORMATION & AUTHORISATION

I understand that tissue removed during my procedure will be sent to the Centre for Oral Pathology & Maxillofacial Diagnostics (COPMD) for microscopic examination and a diagnostic report.

I authorise COPMD to examine the submitted specimen and communicate the report and relevant diagnostic information to my referring or treating clinician. My clinician will explain the findings and any further care required.

I understand that tissue examination is a separate service from the biopsy procedure. The applicable charges and payment arrangements should be explained to me. If additional investigations are recommended, their purpose and charges will be discussed before they are undertaken.

I have had an opportunity to ask questions. I understand the purpose of the examination and consent voluntarily. This authorisation relates to diagnostic examination and reporting; it does not authorise research or publication.

Patient / guardian name: _____

Relationship and reason for guardian consent (if applicable): _____

Signature / thumb impression: _____ Date / time: _____

Witness name and signature (if applicable): _____

Explanation provided by / interpreter (if used): _____

07 REFERRING CLINICIAN CONFIRMATION

I confirm that the patient details, specimen labels and site information have been checked.

Signature / stamp: _____ Date: _____