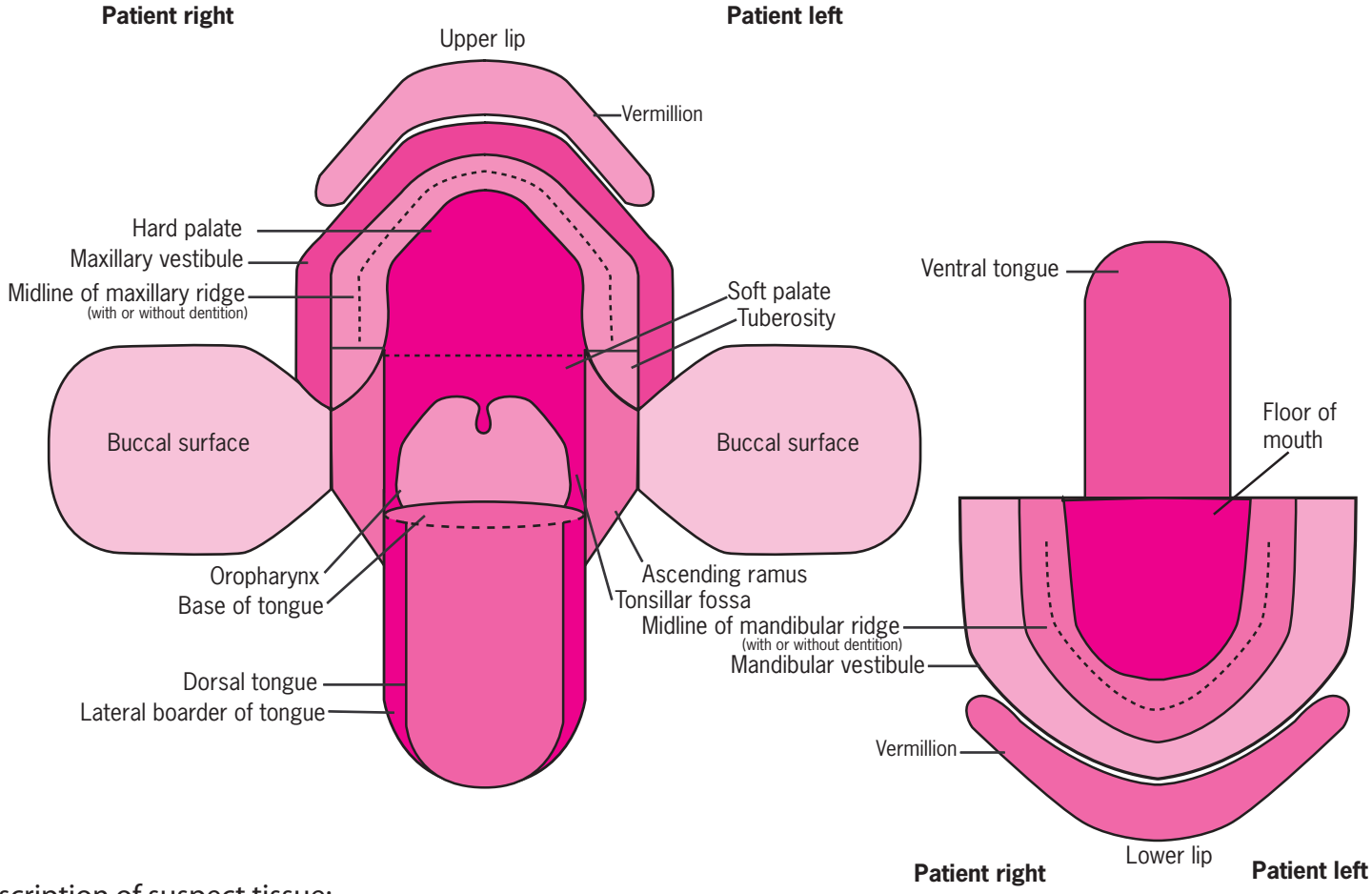
Oral cancer screening referral form

We have found the below detailed abnormality. We believe this area requires further evaluation, and if warranted a biopsy for definitive diagnosis.

Patient name_____
Address_____
City_____Sate____Zip_____
Phone contact number_____ Age_____Sex_____



Description of suspect tissue:

_____
_____
_____
_____
_____
_____

Examining Doctor_____ Printed name_____
Contact information_____

Oral Cancer Screening Referral Form Page 2

APPEARANCE

A. Color

- Red Color
- White Color
- Red/White Color
- Normal overlying mucosa

B. Surface

- Cobblestone texture
- Ulceration
- Smooth

PALPATION

- Firm
- Soft
- Moveable
- Causes bleeding

DIMENSION

- Surface dimension
- Depth dimension

EXTRAORAL FINDINGS

- Neck mass
- Location of neck mass
- Size of neck mass

SIGNS AND SYMPTOMS and HOW LONG HAS EACH BEEN PRESENT

- Sore Throat
- Earache
- Painful swallowing in throat
- Pain at lesion site
- Occasional bleeding at the site
- Awareness of the lesion
- Any change in the lesion

HISTORY

- Smoking
- Alcohol
- Previous lesion in the area with a past diagnosis of _____

CONSULTATION / BIOPSY REQUEST

Date of Referral _____

Referred To:

Dr. _____

Phone _____

Re _____

Date of Birth _____

Please send report to:

Name _____

Address _____

Phone _____

Fax _____

OUR PATIENT HAS PRESENTED WITH A SUSPICIOUS AREA(S) *[please check boxes]:*

- ☐ Lips
- ☐ Labial Mucosa
- ☐ Soft Palate
- ☐ Tongue
  - ☐ Ventral
  - ☐ Dorsal
- ☐ Radiographic
- ☐ Lymph nodes
- ☐ Edentulous ridge
  - ☐ Maxillary
  - ☐ Mandibular
- ☐ Buccal Mucosa
- ☐ Oropharynx
- ☐ Hard Palate
- ☐ Floor Mouth
- ☐ Periodontium
- ☐ Thyroid
- ☐ Orbit
- ☐ Other: _____

☐ **COMMENTS/ADDITIONAL INFORMATION** *[size, color, shape, diagram, and the like]:*

_____

_____

_____

☐ **FAX BIOPSY REPORT ASAP TO:** ( ) _____

PATIENT COMPLAINTS *[please check boxes]:*

- ☐ Pain on swallowing
- ☐ Oral ulceration/tumor
- ☐ Unexplained tooth mobility
- ☐ Thyroid lump
- ☐ Other: _____
- ☐ Sore throat
- ☐ Lump in neck
- ☐ Red or white oral patch
- ☐ Orbital mass

REASON(S) FOR URGENT REFERRAL *[please check boxes]:*

- ☐ Biopsy
- ☐ Further radiographic study
- ☐ Other: _____
- ☐ Second opinion
- ☐ Follow-up biopsy

PLEASE CALL TO DISCUSS AFTER EXAMINING OUR PATIENT

Doctor Signature: _____ Date: _____

Patient Signature: _____ Date: _____

IMPORTANT: One copy must remain in the patient's chart. Patient must be closely monitored (no more then two weeks can pass without knowing the status of the referral) until consultation request has been fulfilled and suspicious area has been definitively diagnosed. A chart entry must be made of this referral, along with any specific instructions provided to the patient.