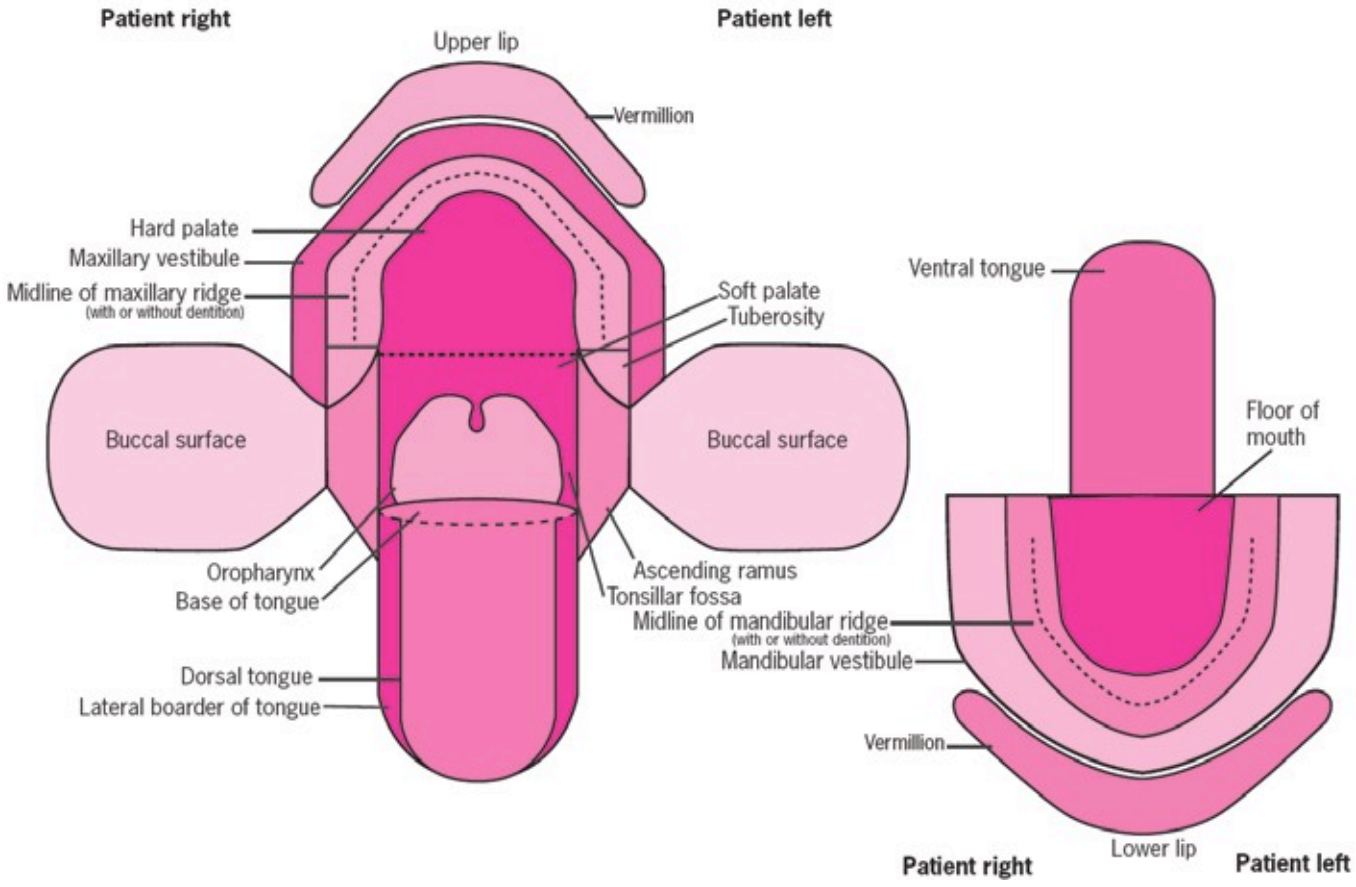
Oral Cancer Screening - Referral Form

The patient that brought you this form was screened at a public screening event. Below, we have listed the detailed abnormality that we believe requires further evaluation and, if warranted, a biopsy for definitive diagnosis.

Patient Name_____
Address_____
City_____ State_____Zip_____
Phone Number_____Age____Sex_____



Description of suspect tissue:

_____

_____

_____

_____

_____

_____

Examining Doctor/Hygienist_____Printed Name_____

Contact Information_____

EXAMINATION:

APPEARANCE

A. Color

- O Red Color
- O White Color
- O Red/White Color
- O Normal Overlying Mucosa

B. Surface

- O Cobblestone Texture
- O Ulceration
- O Smooth

PALPATION

- O Firm
- O Soft
- O Moveable
- O Causes Bleeding

DIMENSION

- O Surface Dimension
- O Depth Dimension

EXTRAORAL FINDINGS

- O Neck Mass
- O Location of Neck Mass
- O Size of Neck Mass

SIGNS AND SYMTOMS and HOW LONG HAS EACH BEEN PRESENT

- O Sore Throat
- O Earache
- O Painful Swallowing in Throat
- O Pain at Lesion Site
- O Occasional Bleeding at the Site
- O Awareness of the Lesion
- O Any Change in the Lesion

HISTORY

- O Smoking
- O Alcohol
- O Previous Lesion in the area with a past Diagnosis of _____