

REFERRAL INFORMATION

Date: _____

Patient name: _____ Telephone #: _____

Referred by: _____ *Please call me to discuss: YES No

This patient is referred for: *Telephone #: _____

- Oral lesion assessment; oral diagnosis
- Oral lesion management
- Biopsy
- Non-healing ulcer(s)
- Melanosis/nevus
- Bad taste/halitosis
- White lesion(s)/leukoplakia/dysplasia
- Erythroplakia
- Desquamative gingivitis
- Oral/facial pain evaluation
- Non-dental/neuropathic toothache
- Burning tongue/mouth pain
- Trigeminal neuropathy/neuralgia
- Temporomandibular joint dysfunction (pain, locking, trismus)
- Myofascial pain
- Bisphosphonate jaw necrosis/symptoms
- Xerostomia
- Sialorrhea
- Salivary diagnostics - HPV
- Salivary gland enlargement/infection
- Sjögren's syndrome evaluation
- Radiation &/or chemotherapy oral evaluation/management (pre/peri/post)
- Sleep apnea/snoring: oral appliance therapy
- Sleep study/eval. needed

Are radiographs/imaging available from the last 12-18 months? YES No

IF YES, what type : Panoramic FMX Periapicals/BW's CT MRI

Additional lesion, pain, salivary, sleep, oncologic &/or case history/comments:

Patients may call **949.586.7000** to schedule an appointment.

This referral form can be faxed to **949.586.0158** and/or given to your patient.