The Dental Center at Western University of Health Sciences

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The Dental Center at Western University
Oral Pathology Referral Form

***Referring Doctor: Please fill out completely and fax a copy of this request form prior to patient appointment*

REFERRAL INFORMATION

Date:_________________

Patient name:________________________ Patient Telephone #:_______________________________

Referred by:_________________________ *Please call me to discuss:☐YES ☐No

This patient is referred for: *Referring Doctor 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/Medication-related osteonecrosis/symptoms

☐ Xerostomia ☐ Sialorrhea ☐ Salivary diagnostics

☐ 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/evaluation 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:

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