Oral Pathologist/Oral Surgeon Referral Form

Mr./Mrs. ____ was seen today in our practice.

Age: __________ If Child, accompanied by: ☐ Parent ☐ Grandparent ☐ Other: ______________

Reason for patient visit:

☐ Periodic Recare ☐ Specific Concern

Please list details:

Please evaluate the specific area(s) noted below for intraoral examination:

☐ Lips/Perioral area
☐ Palate Anterior
☐ Vestibule
☐ Retromolar Trigone
☐ Floor of the Mouth
☐ Gingiva
☐ Buccal Mucosa
☐ Tongue Dorsum
☐ Tongue Ventral
☐ Labial Mucosa
☐ Palate Posterior
☐ Tongue Lateral
☐ Oropharynx and Tonsil Region

Specific concerns for evaluation of head and neck area:

☐ Craniofacial/Headache
☐ TMJ
☐ Upper / Med / Lower Face: ☐ Left ☐ Right ☐ Both
☐ Midline / Anterior / Lateral Posterior Neck: ☐ Left ☐ Right ☐ Both

Level of pain reported by patient: (pain): Lowest - 0 1 2 3 4 5 6 7 8 9 10 - Highest

Location of Pain Perception from above list: ________________________________

Specific tooth number of pain association: ________________________________

Lesion description and history: (measurements, color, consistency, and general impression):

Listed below please find any relevant medication/drug history and/or medical history:

Pertinent medical history:

Pertinent drug history:

☐ Digital image is attached.
☐ Oral digital or hard copy radiograph of lesion are attached.
☐ Digital or hard copy clinical image is attached.

From the office of:

Dr. ____

Address: ____

Phone: ______________________________ Fax: ______________________________

Date: ____

Please call our office if you have any further questions or need more information.