UNIVERSITY HOSPITALS & CLINICS
DEPARTMENT OF ORAL & MAXILLOFACIAL SURGERY
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Tel: 503-494-8916 Fax: 503-494-6783 www.ohsu.edu/sod/omfs

PATIENT REFERRAL INFORMATION

Date ________________

❒ Leon A. Assael, DMD ❒ Mark Engelstad, DDS, DMD, MHI
❒ Julie Ann Smith, DDS, MD ❒ Robert W. T. Myall, BDS, MD ❒ General Referral

(In order to expedite patient care, please fill out this form in its entirely)

REFERRING PROVIDER: ____________________ **FACULTY:** ____________________
ADDRESS: ____________________ **PHONE:** ____________________
CITY, STATE, ZIP: ____________________ **FAX:** ____________________
PRIMARY CARE PROVIDER: ____________________
ADDRESS: ____________________ **PHONE:** ____________________
CITY, STATE, ZIP ____________________ **FAX:** ____________________

PATIENT NAME ____________________ **PHONE:** ____________________
ADDRESS: ____________________ **BIRTHDAY:** ____________________
____________________ **SSN:** ____________________

DENTAL INSURANCE: ____________________ **PHONE:** ____________________
AUTHORIZATION#: ____________________ ____________________
MEDICAL INSURANCE: ____________________ **PHONE:** ____________________
AUTHORIZATION: ____________________ ____________________

REASON FOR REFERRAL: ____
____

RELEVANT MEDICAL HISTORY: ____
____

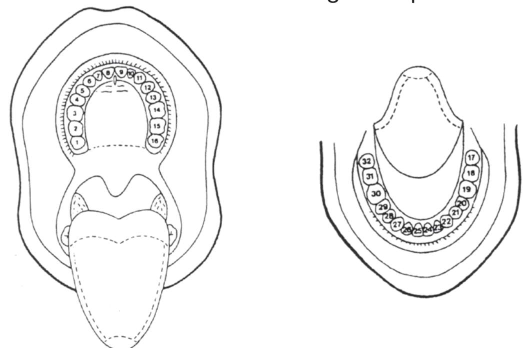
<u>CHECK ONE PLEASE</u>

❒ X-rays Emailed ❒ X-rays mailed ❒ Pt. to bring current x-rays ❒ Needs imaging ❒ No imaging necessary

❒ Cosmetic
❒ Craniofacial
❒ Apicoectomy
❒ Dental Implant
❒ Maxillofaical Nerve Injury
❒ Orthognathic
❒ Extraction
❒ Pathology
❒ Pre-Prosthetic
❒ Infection
❒ Reconstructive
❒ TMJ/Facial Pain Eval.
❒ Trauma
❒ Surgical Exposure

1 2 3 4 5 6 7 8	9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25	24 23 22 21 20 19 18 17

A B C D E	F G H I J
T S R Q P	O N M L K



SIGNED (REFERRING DOCTOR)____________________

*****PLEASE HAVE YOUR PATIENT CONTACT US TO SCHEDULE APPOINTMENT*****