COLLEGE OF DENTISTRY

Changing the Future of Oral Health

UIC COLLEGE OF DENTISTRY PATIENT REFERRAL
ORAL MEDICINE AND FACIAL PAIN CLINIC

PLEASE BRING THIS FORM ALONG WITH ALL NECESSARY MEDICAL REPORTS, IMAGING, and BIOPSY REPORTS

Fax to: (312) 355-1229
For appointments: (312) 355-1222

Referral Date: ____________________

Patient Information:

Patient's Name: ____DOB: ______________Gender: ______

Home Address: ____

City, State, Zip: ____

Phone: ____________________________ Email: ____

Insurance Plan/Provider: ____

How long has the patient been with your practice?____

Referring Practice/Provider:

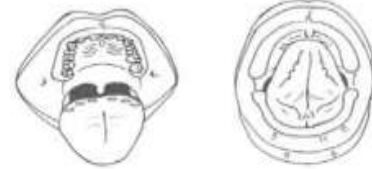
Practice Name: ____

Provider/Doctor Name: ____

Phone: _______________________ Email: ____

Reason(s) for referral (check all that apply

- ☐ Oral lesions
- ☐ Intraoral / Extra oral Swelling
- ☐ TMJ joint/muscle issues
- ☐ Clenching or grinding / bruxism
- ☐ Intraoral pain
- ☐ Headaches



Please provide a brief description of the condition or symptoms the patient is experiencing:

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PLEASE NOTE: WITHOUT A BRIEF DESCRIPTION AND EXPLANATION OF THE CHIEF COMPLAINT OF THE PATIENTS CONDITION, THE PATIENT REFERRAL WILL BE CONSIDERED VOID.

Consultant's Report – Please Print

Date Answered: _____________________

Recommendations:

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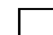
Doctor's
Name:_____________________________________Signature:____

University of Illinois at Chicago College of Dentistry



dentistry.uic.edu/patients