BOSTON MEDICAL CENTER
EXCEPTIONAL CARE. WITHOUT EXCEPTION.
The primary teaching affiliate of the Boston University School of Medicine.

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Referral for Oral Pathology

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***PLEASE BE SURE TO SEND RELEVANT PATHOLOGY REPORTS, RADIOGRAPHS OR CLINICAL PHOTOS AS NECESSARY (E-mail is preferred)

Referring clinician: (*Please Print Name*)

_____

Address of referring clinician:

_____
_____

Telephone of referring clinician: _____

Fax of referring clinician: _____

We are referring following patient:

Patient Name: _____
Birthdate: _____
Address: _____
Telephone: _____
Medical Insurance: _____

REASON OF REFERRAL:

_____
_____
_____
_____

Relevant History:
(*Indicate any special factors- such as known allergies and specific medical problems relevant to diagnosis and treatment*)

_____
_____
_____

Signed: _____Date:_____