Referral Form
UNC Hospitals Oral Medicine
101 Manning Drive, Chapel Hill, NC 27514
Phone (984) 215-6810
Fax (984) 974-0355

UNC Hospitals Oral Medicine

Patient Referral Form

Thank you for your interest in referring your patient to UNC Hospitals Oral Medicine. Referrals are accepted via Epic, fax, or email. If you have any questions about our clinic's referral policy, please contact our office. Incomplete referrals will not be processed.

PATIENT INFORMATION

First Name _____ Middle Initial _____ Last Name _____

Date of Birth _____ /_____ /_____ Phone # _____

REASON FOR REFERRAL

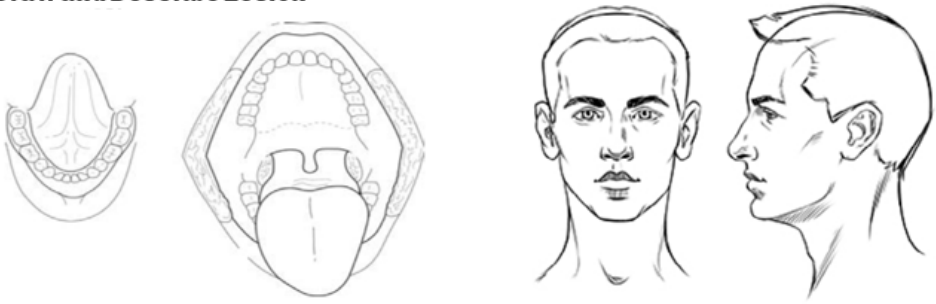
Please indicate the primary reason for the referral:

- ❑ ORAL MUCOSAL DISORDERS (red/white lesion, nodule, mass, pigmentation, ulcer)
- ❑ INFECTION (bacterial, fungal, viral)
- ❑ OROFACIAL PAIN (TMD, neuropathic pain, neuralgia)
- ❑ ORAL PRE-CANCER AND CANCER SURVEILLANCE (leukoplakia, lip pre-cancer, post-cancer treatment surveillance)
- ❑ ORAL COMPLICATIONS FROM CANCER THERAPY (dry mouth, jaw necrosis, mucositis, GVHD, trismus, dysgeusia)
- ❑ SALIVARY GLAND PATHOLOGY (Sjogren syndrome, salivary changes, taste changes)
- ❑ OTHER

Please describe diagnosis/condition_____

_____

Draw and Describe Lesion



REFERRING PROVIDER

Referring Doctor _____ Phone # _____ Fax # _____

Email _____ Address _____

Please attach/e-mail relevant medical history, x-rays, blood tests, cultures, clinical images, and biopsy reports.

Fax: (984) 974-0355 **Email:** oralmed@unc.edu **Phone:** (984) 215-6810