MICHIGAN MEDICINE
UNIVERSITY OF MICHIGAN

University of Michigan
Hospital Dentistry Referral

Hospital Dentistry Clinic
U of M Medical Center
Phone: 734-763-8006
Fax: 734-936-6159

Please complete the information below so we can triage and most expeditiously provide care for your patient. Fax completed form to 734-615-6159. *Incomplete forms will be returned for completion.*

Patient Name: _____ D.O.B._____

Dental Insurance _____ SS#_____

Contact Person _____ Relationship _____

Patient's Address _____

City _____ State _____ Zip Code _____

Phone (day) _____ Cell Phone _____

If the patient is a Wayne/Oakland/Macomb resident, has a referral been made to the University of Detroit/University Hospital? Circle one. Y N Result_____

Reason for referral: _____

Is the patient neurologically impaired? Circle one. Y N

Check all medical conditions that apply:

___organ transplant ___immunologically compromised ___history of radiation therapy ___limited opening

___pre-cardiac surgery ___history of head & neck surgery ___blood dyscrasia ___cancer other_____

Current signs/symptoms:_____

Medical history: _____

Medications: _____

Allergies: _____

Dentist name, address, and phone: _____

_____

_____

Oral examination reveals: _____

The following treatment has been provided: _____

If you have radiographs, please have the patient bring them at the time of their apt.

----------OFFICE USE ONLY----------

___Screen ___GPR ___Dr. Cornwall ___Dr. Munz ___Dr. Ashman ___Dr. Chang ___Max. Prosth. ___O.S. ___Oral Med

___Pedo ___DS ___Send Letter ___Need more info ___UofD/other Wayne ___PAES(3-1379) ___Redwood ___Other