MICHIGAN MEDICINE
UNIVERSITY OF MICHIGAN

Hospital Dentistry Clinic
University of Michigan Dental Referral

Hospital Dentistry Clinic
U of M Medical Center
Phone: 734-763-8006
Fax: 734-615-6159

Thank you for your interest in referring a patient to University of Michigan, either the Hospital Dentistry Clinic or the School of Dentistry. Please complete the information below so we can triage and most expeditiously provide care for your patient. Fax the completed form to the number listed above.

Patient Name: _____ D.O.B._____

U of M Registration # (if known) _____ SS#_____

Contact Person _____ Relationship _____

Patient's Address _____

City _____ State _____ Zip Code _____

Phone (Day) _____ Phone (eve) _____ Phone (other) _____

Reason for Referral _____

Current signs/symptoms _____

Is the patient medically compromised or neurologically impaired? If yes, please describe. _____

_____

Based on assessment, can the patient be treated in a routine dental setting? If no, please explain. _____

_____

If the patient is a Wayne/Oakland/Macomb resident, has a referral been made to the University of Detroit/University Hospital? _____ Result _____

Medical History _____

Medications _____

Allergies _____

Physician name, address, phone: _____

_____

If referred by a dentist: _____

Oral examination reveals: _____

The following treatment has been provided: _____

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

Your name _____ Ph _____ Fax _____

Email: _____

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

___Screen ___GPR ___Dr. Zwetchkenbaum ___Dr. Cornwall ___O.S. ___Oral Med ___Pedo

___School ___Send Letter ___Need more info ___UofD/OtherWayne ___Fax to PAES (3-1379)

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