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ORAL MEDICINE REFERRAL FORM

Patient: _____

Age: _____ Referred by: _____

Appointment date: _____ Time: _____

Preliminary diagnosis

- Chronic Pain
  - TMD or Jaw Pain
  - Trigeminal Neuralgia
  - Odontalgia
  - Salivary Gland Disease
  - Other
- Oral lesions
  - Ulcers
  - Herpes
  - Aphthous Stomatitis
  - Candidiasis
  - Pigmented Lesion
  - Sun-Damaged Lips
  - Oral Cancer
  - Other
  - Biopsy Requested
- Intraoral Autoimmune Diseases
  - Lichen Planus
  - Mucous Membrane Pemphigoid
  - Pemphigus
  - Sjogren's Syndrome
  - Lupus
  - Other
- Medically Compromised
  - Heart
  - Lung
  - Kidney
  - Wheelchair
  - Stretcher
  - Other
- Immunocompromised
  - Hepatitis
  - HIV
  - TB
  - Other
- Dry Mouth
  - Burning Mouth
  - Xerostomia
  - Adverse Drug Reactions

ADDITIONAL NOTES: _____

_____

_____

DATE: _____ **RE:** _____