University of California
San Francisco
UCSF
Fresno Medical Education Program

ORAL & MAXILLOFACIAL SURGERY

OMFS CARE CENTER
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Phone: (559) 459-4101 * Fax: (559) 459-5744

CONSULTATION REFERRAL FORM

Date: _____

Patient's Name: _____ DOB: _____

(Guarantor/Parent/Legal Representative If applicable) Name: _____

Address: _____ City/State/Zip: _____

Home Phone Number: _____ Work/Cell/Other: _____

(OMFS office use only) Appointment: _____ at _____ _____
Date Time Primary Language

Referring Provider (Office Name): _____

Referring Provider (Full Name Please): _____

Address & Zip Code: _____

*** Referring Provider NPI (REQUIRED): _____ ***

Referring Provider Fax #: _____ Office #: _____

Office e-mail: _____ Office Contact Name: _____

Please Circle requested treatment and add any necessary details.

1) Referred for Extraction of Teeth indicated below:

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
Right	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	Left

Right	A	B	C	D	E	F	G	H	I	J	Left
	T	S	R	Q	P	O	N	M	L	K	

2) Maxillofacial Fractures: _____

3) Maxillofacial Cyst/Tumor: _____

4) Head/Neck Cancer: _____

5) Orthognathic Surgery (In Active Ortho Treatment: YES / NO): _____

6) Pre-prosthetic Surgery: _____

7) Biopsy: _____

8) Implants/Bone Graft (Must Attach Perio Charting w/in Year): _____

9) Nasal Surgery: _____

10)Cleft Lip/Palate: _____

**HEALTH HISTORY _____

_____

Other Instructions: _____

Radiographs Available: ☐ **Yes** ☐ **No** **Report Available:** ☐ **Yes** ☐ **No**

INSURANCE COVERAGE (REQUIRED): ALL billing information

Dental Coverage: ☐ **Yes** ☐ **No** **Medical Coverage:** ☐ **Yes** ☐ **No**

PLEASE PRINT CLEARLY & ON LEGIBLE REFRRAL
ATTACH ALL INSURANCE CARDS AND AUTHORIZATIONS

SEND TO FAX: (559) 459-5744 EMAIL: ucsffresnoomfs@communitymedical.org