



## Patient Referral Form

**2700 Martin Luther King Jr. Blvd.  
 Detroit, MI 48208-2576  
 313-494-6700**

**University Health Center, 4201 St. Antoine  
 Detroit, MI 48201  
 313-494-6700**

### PATIENT INFORMATION

Last name:	First name:	Sex:
Phone: (     )	Date of Referral:	DOB:

### DEPARTMENT FOR REFERRAL (PLEASE CHECK ALL THAT APPLY)

<input type="checkbox"/> Oral Surgery (313)494-6648	<input type="checkbox"/> Periodontics (313)494-6647
<input type="checkbox"/> Orthodontics (313)494-6731	<input type="checkbox"/> Endodontics (313)494-6729
<input type="checkbox"/> Diagnostic Imaging (313)494-6718	<input type="checkbox"/> <i>Advanced Education in General Dentistry</i> AEGD (313)494-6873
<input type="checkbox"/> Faculty Practice (313)494-6730	<input type="checkbox"/> Pedodontics (313)494-6701

### REASON FOR REFERRAL

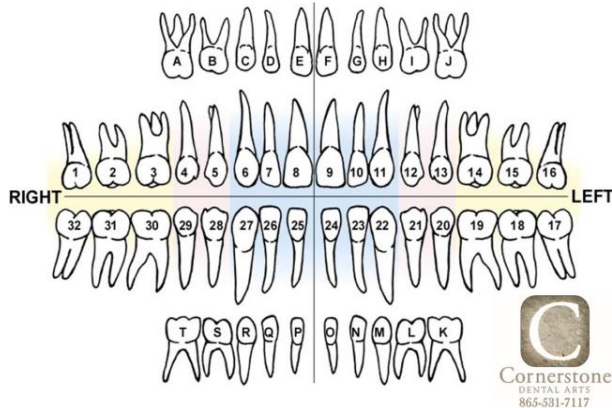
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### REFERRING DENTIST MUST PROVIDE THE FOLLOWING INFORMATION

Date of last exam:	Date of last FMS:	Date of last BW x-rays:
Patient returning to referring doctor for final restoration	<input type="checkbox"/> Yes <input type="checkbox"/> No	If no please provide details

Referred by: \_\_\_\_\_

Address: \_\_\_\_\_

City/Zip code: \_\_\_\_\_

Telephone number: (     ) \_\_\_\_\_

Signature of referring Dr. \_\_\_\_\_ NPI Number: \_\_\_\_\_