



Patient Referral Form
 2700 Martin Luther King Jr. Blvd.
 Detroit, MI 48208-2576

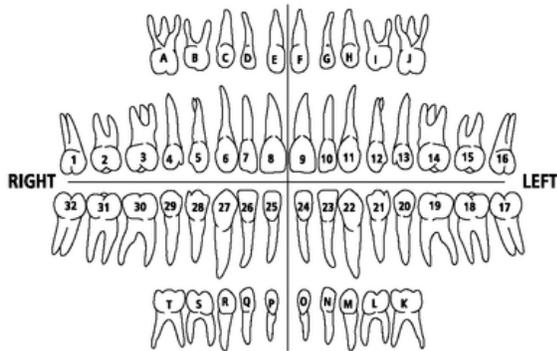
PATIENT INFORMATION

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

DEPARTMENT FOR REFERRAL (PLEASE CHECK ALL THAT APPLY)

<input type="checkbox"/> Oral Surgery	Phone: 313-494-6648	Fax: 494-6920	<input type="checkbox"/> Periodontics/Implants	Phone: 313-494-6647	Fax: 494-6666
<input type="checkbox"/> Orthodontics	Phone: 313-494-6731	Fax: 494-6605	<input type="checkbox"/> Endodontics	Phone: 313-494-6729	Fax: 494-6842
<input type="checkbox"/> Radiology/CBCT	Phone: 313-494-6718		<input type="checkbox"/> Pedodontics	Phone: 313-494-6701	
<input type="checkbox"/> Faculty Practice	Phone: 313-494-6730				

REASON FOR REFERRAL



REFERRING DENTIST MUST PROVIDE THE FOLLOWING INFORMATION

Date of last exam:	Date of last FMS:	Date of last BW:
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:
Please send all images in <u>JPEG format only</u> to radiology@udmercy.edu		
Periodontics referrals will only accept FMX radiographs; PAN radiographs will not be accepted		