DETROIT MERCY DENTAL CLINIC

Patient Referral Form

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

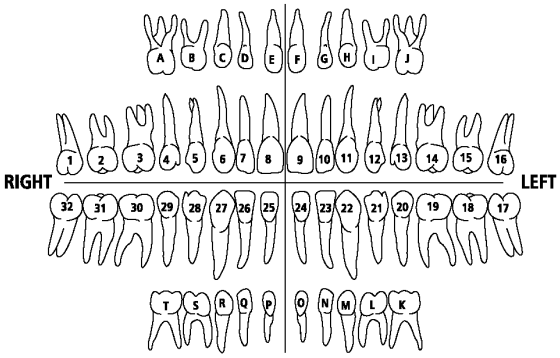
PATIENT INFORMATION

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

DEPARTMENT FOR REFERRAL (PLEASE CHECK ALL THAT APPLY)

☐ Oral Surgery	Phone: 313-494-6648	Fax: 494-6920	☐ Periodontics/Implants	Phone: 313-494-6647	Fax: 494-6666
☐ Orthodontics	Phone: 313-494-6731	Fax: 494-6605	☐ Endodontics	Phone: 313-494-6729	Fax: 494-6842
☐ Radiology/CBCT	Phone: 313-494-6718		☐ Pedodontics	Phone: 313-494-6701	
☐ 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	☐ Yes ☐ No	If no please provide details:
Referred by:		
Address:		
City/Zip code:		
Telephone number: ( )		
Signature of referring Dr.		NPI Number:

All radiographs must be submitted in JPEG format to radiology@udmercy.edu

Periodontics referrals will only accept FMX radiographs; PAN radiographs will not be accepted.