dentalfacultypractice
at The Ohio State University

ORAL PATHOLOGY CONSULTANTS
PATIENT REFERRAL

Preferred Pathologist:

☐ any available
☐ Christine Harrington, DDS, MS
☐ Kristin K. McNamara, DDS, MS

Referred By:

Name: _____

Facility: _____

Phone: _____

Patient Information:

Name: _____

Date of Birth: _____ Gender: ☐ M ☐ F

Address: _____

_____

Phone: _____

Dental Ins.: _____

Medical Ins.: _____

ID#: _____

Referral notes, x-rays:

Mailed on (Date)_____

☐ Patient to bring to consult

E-mailed by secure email to DFPrecords@osu.edu on (Date)_____

Faxed to 614-292-4960 on (Date) _____

Reason for Referral:

Specific concerns:

Significant Medical History (required):

Signature of Referring Provider: _____ Date: _____

Thank you for your referral.

Dental Faculty Practice | Postle Hall, 4th Floor | 305 West 12th Avenue | Columbus, Ohio 43210
Phone: 614-292-1472 | Option 2: Scheduling, Option 3: Insurance/Preauthorization
Fax: 614-292-4960 | Secure email: DFPrecords@osu.edu