UCONN
SCHOOL OF DENTAL MEDICINE

Clinical Oral Pathology
Consultation Request Form

Tel: (860) 679 3170
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For appointments, please fax or email the completed form directed to "UConn Oral Pathology"
Fax: (860) 679 3201
Email: universitydentists@uchc.edu

Date:

Patient gives permission to release information (Y/N)

Referring Provider's Office/ Clinic				Patient Information (all fields required)			
Provider:				**Patient Name:**			
Address:				**Address:**			
Address:				**City:**		**Zip:**	
City:		**Zip:**		**Phone:**			
State:				**Med. Insurance:**			
Fax:				**Insurance #:**			
Phone:				**Group #:**			
Email:				**Insured's Name:**			
Physician Signature							

Please provide (fax or email) a copy of the patient's medical insurance cards if available

Referring Provider – Clinical History and Diagnostic Impression.

Urgent? Please indicate "Yes" or "No"	**YES**		**NO**	