Center for Integrative Oral Health Inc.

7151 University Blvd, Suite 110, Winter Park, Florida 32792

Phone: 407-636-6003 Fax: 407-636-6019 email: info@inoralhealth.com

Patient Name

Patient telephone

Referring Dentist/ Dental specialist name NPI:

Dentist/ Dental specialist telephone

Reason for referral: Consult/ Evaluate and manage

Priority: Immediate/ Critical and treatment plan pending consult/ Consult or E/M- non urgent

Chief complaint of _____ Duration _____

Please check all that apply:

Oral Mucosal lesions: Oral ulcers, Oral Lichen planus, mucositis, mucocutaneous lesions	Infectious and Inflammatory conditions, Viral, Bacterial, Fungal Infections
Temporomandibular Joint Disorders (TMD) and headaches from TMD	Orofacial pain/ trigeminal neuropathic pain/ Facial and Trigeminal Neuralgias
Dental care for Geriatric /medically complex patient	Dental care for oncology patients
Dry mouth/ salivary gland dysfunction	Burning Mouth/ Oral Burning
Oral Complications from Cancer Treatment	Oral Evaluation for Taste & Smell Disorders,
Pre /post chemotherapy consult and recommendation for safe dentistry	Pre /post radiation therapy consult and recommendation for safe dentistry
Oral appliance therapy for Sleep apnea	Bad Breath (Halitosis)

Other _____

Patient currently being treated for the condition referred [palliative, empiric etc.,]- Yes / No

Current treatment for this condition/ other relevant information

Medical history/ current Medications/ dental radiographs/ CBCT/ photographs enclosed - Yes [ ] No [ ]

Please email dental radiographs/ CBCT/ photographs to info@inoralhealth.com

Thanks,
Sincerely,

[Referring Physician's signature and office contact information]