SOL SILVERMAN ORAL MEDICINE CLINIC
513 Parnassus Avenue, Suite S722, San Francisco, CA 94143-0422
Phone: 415-476-2045 Fax: 415-514-2862

REFERRAL FORM

*PLEASE READ: We are not in-network with HMO medical plans. If this patient has an HMO plan, please submit a pre-authorization with the referral. If the patient does not have an approved medical insurance pre-auth at the time of their appointment, then they will be self-pay. Please call us with any insurance questions. Thank you.

Referring Clinician Name:_____
Office Phone: _____ Office Fax: _____

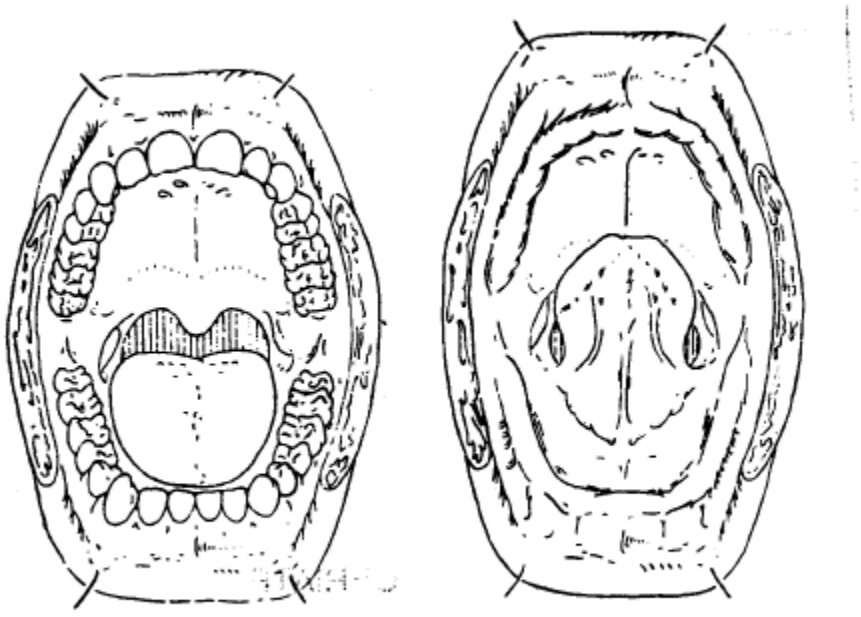
Patient Name: _____
Date of Birth: _____ Patient Phone: _____

Chief Complaint: _____

Oral Examination Findings (please briefly describe lesion character, color, and location. Use mouth diagram below if necessary)

_____
_____

Oral lesion location (circle area on diagram)



NORMAL EDENTULOUS

Signature of Referring Clinician: _____ Date:_____

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ADDITIONAL INFORMATION

Please fax this completed form and a copy of the front and back of the patient's medical insurance card(s) to our secure clinic fax at 415-514-2862 or our secure clinic email at OralMed@ucsf.edu.

Please included any pertinent biopsy and/or clinical laboratory report and radiographs.

We are located at Suite 722 on the seventh floor of the Medical Sciences building at 513 Parnassus Ave