

## Joshua S. Goldfaden, DDS

### ORAL MEDICINE, MUCOSAL DISEASES & ONCOLOGY REFERRAL FORM

12835 Pointe Del Mar Way #3, Del Mar, CA 92014 | Phone: (858) 683-1437 | Fax: (858) 365-5618 | Email: jgold@scopeoralpain.com

*Confidential Medical Notice: The thorough health history below is required under HIPAA. It assists us in achieving an accurate and safe diagnosis and treatment plan for you.*

#### 1. REFERRING PROVIDER INFORMATION

Provider Name: \_\_\_\_\_ Credentials: \_\_\_\_\_  
Practice/Organization: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

#### 2. PATIENT INFORMATION

Full Legal Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Street Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Email: \_\_\_\_\_

#### 3. REASON FOR REFERRAL

##### Check all that apply:

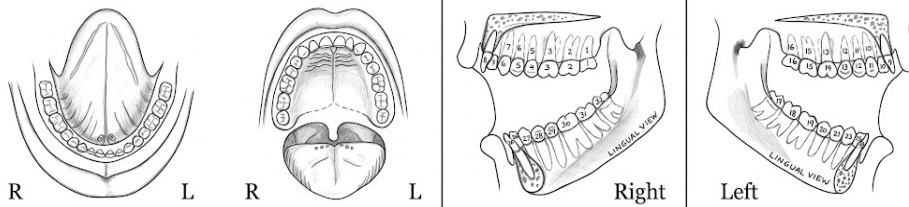
- |                                                                                                         |                                                                          |
|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|
| <input type="checkbox"/> Persistent oral ulcer/erosion (duration: _____)                                | <input type="checkbox"/> Burning mouth/oral dysesthesia                  |
| <input type="checkbox"/> White or red mucosal lesion (leukoplakia/erythroplakia)                        | <input type="checkbox"/> Chronic oral pain of unknown origin             |
| <input type="checkbox"/> Suspected vesiculobullous disease (e.g., pemphigus, pemphigoid, lichen planus) | <input type="checkbox"/> Complications from cancer therapy               |
| <input type="checkbox"/> Suspected oral malignancy or premalignancy                                     | <input type="checkbox"/> Salivary gland disorder/xerostomia evaluation   |
| <input type="checkbox"/> Oral soft tissue biopsy                                                        | <input type="checkbox"/> Recurrent aphthous stomatitis/complex aphthosis |

Other: \_\_\_\_\_

#### 4. CLINICAL DETAILS

*If available, please include all relevant documentation (e.g., pathology/biopsy results, clinical photographs, radiographs, lab results, prior consultation notes, medication lists).*

Location of Lesion/Concern (please circle/label):



Symptoms and Duration: \_\_\_\_\_

Size (if known): \_\_\_\_\_

Has a biopsy been performed: Yes / No

If yes, date and result: \_\_\_\_\_

Worsening / Stable / Waxing / Waning

Color/Appearance: \_\_\_\_\_

Previous treatments attempted and response: \_\_\_\_\_

#### 5. REFERRING PROVIDER SIGNATURE & AUTHORIZATION

I certify that the above information is accurate and authorize Joshua S. Goldfaden, DDS to evaluate and treat the above-named patient. I authorize the exchange of relevant medical/dental records between our offices for continuity of care in accordance with HIPAA regulations.

Referring Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**6. FOR OFFICE USE ONLY**

---

Date Referral Received: \_\_\_\_\_ Appointment Scheduled: \_\_\_\_\_

Reviewer Initials: \_\_\_\_\_ Notes: \_\_\_\_\_