Joshua S. Goldfaden, DDS

ORAL MEDICINE, MUCOSAL DISEASES & ONCOLOGY REFERRAL FORM

12835 Pointe Del Mar Way #3, Del Mar, CA 92014 | Phone: (248) 633-5965 | 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 INORMATION

Full Legal Name: _____ DOB: _____

Street Address: _____ City/State/Zip: _____

Phone: _____ Email: _____

3. REASON FOR REFERRAL

Check all that apply:

[ ] Persistent oral ulcer/erosion (duration: _____)

[ ] White or red mucosal lesion (leukoplakia/erythroplakia)

[ ] Suspected vesiculobullous disease (e.g., pemphigus, pemphigoid, lichen planus)

[ ] Suspected oral malignancy or premalignancy

[ ] Oral soft tissue biopsy

[ ] Burning mouth/oral dysesthesia

[ ] Chronic oral pain of unknown origin

[ ] Complications from cancer therapy

[ ] Salivary gland disorder/xerostomia evaluation

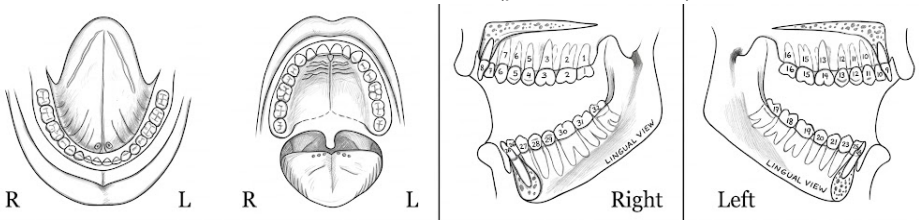
[ ] Recurrent aphthous stomatitis/complex aphthosis

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: _____ Worsening / Stable / Waxing / Waning

Size (if known): _____ Color/Appearance: _____

Has a biopsy been performed: Yes / No

If yes, date and result: _____

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:

_____