UNLV | SCHOOL OF DENTAL MEDICINE

UNLV Oral Pathology and Oral Medicine Referral

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REFERRING DOCTOR	**PATIENT INFORMATION**
Name:	Name (Last): (First):
Address:	Gender: ☐ M ☐ F
City: State: Zip:	Birth Date: __ __ /__ __ /__ __ __ __
Phone:	Phone:
Fax:	
E-mail:	

REASON FOR REFERRAL: ____

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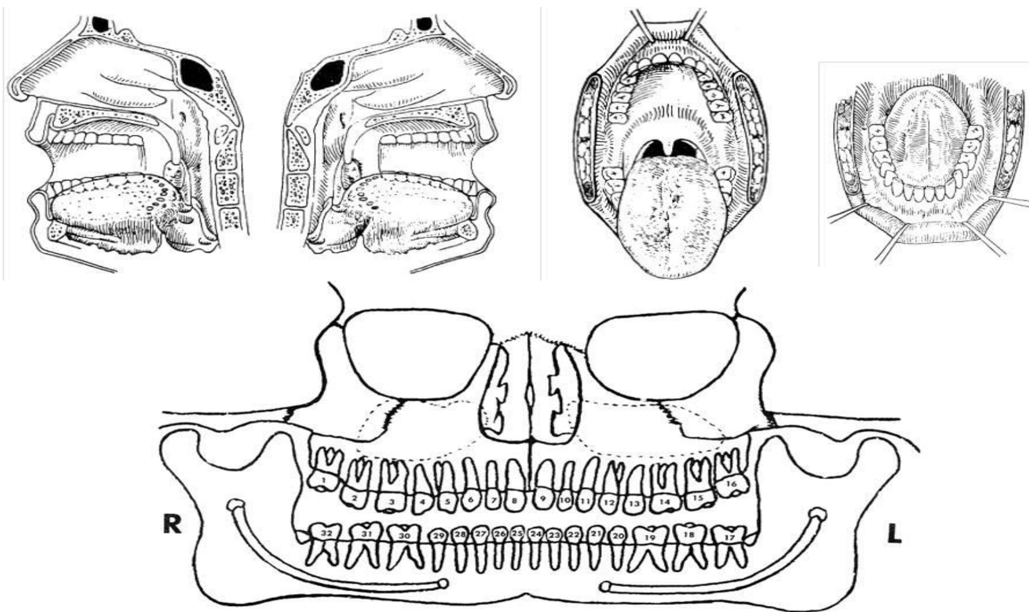
LOCATION OF LESION(S):____



MEDICAL AND SOCIAL HISTORY:____

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** **Please E-mail any clinical photographs or relevant radiographs to moni.ahmadian@unlv.edu** **