JOEL B. EPSTEIN DMD, MSD FRCD(C), FDS RCS(E),
Diplomate American Board of Oral Medicine

Patient Referrals

Date: _____

Patients Name_____**DOB**_____

Reason for Referral: **(please circle)**

- **Mucosal lesion: leukoplakia, erythroplakia, lichen planus, mass, ulceration; other:**_____
- **Infection: Candidiasis, herpes, other**_____
- **Xerostomia, taste change**
- **Orofacial pain: burning sensation, neuropathic pain, neuralgia**
- **Headache / TMD**
- **Injury (describe):**_____
- **Other, please explain:**

_____

_____

Related Medical History: _____

_____

Imaging & Related Medical Lab tests:

_____

Referring Doctor's Name: _____

Address:

_____

_____

Phone: _____ **Fax:** _____

Locations: (please check)

- ○ **Bellingham – 3400 Squalicum Pkwy – Ste 107 – Bellingham, WA 98223 Phone No. 360-255-2052**
- ○ **California – 8500 Wilshire Blvd – Ste 800 - Beverly Hills, CA 90211 Phone No. 310-652-8500**
- ○ **Chicago - 811 W. Wellington – Chicago, IL 60657 Phone No. 773-871-4964**