JOEL B. EPSTEIN DMD, MSD FRCD(C), FDS RCS(E)

Diplomate American Board of Oral Medicine, Certified Specialist Oral Medicine (BC)

Patient Referral

Date: _____

Patients Name: First_____ Last:_____

Patient contact information: Phone _____ Email: _____

Reason for Referral: (please circle)

O Mucosal lesion: leukoplakia, erythroplakia, lichen planus, mass, ulceration; Other _____

O Infection: Candidiasis, herpes, other_____

O Xerostomia, taste change

O Orofacial pain: burning sensation, neuropathic pain, neuralgia

O Headache / TMD; Trauma Injury (describe):_____

O Other, please explain: _____

Related Medical History:_____

_____

Imaging & Related Medical Lab tests: _____

Referring Doctor:____ _____Address: _____

Phone:_____ Fax: _____ Email: _____

Office locations: (please check)

O California – 99 N. La Cienega Blvd. Ste 308- Beverly Hills, CA 90211 Ph 310-652-8500 F 310-652-6492

Email: oralmedicinepacific@gmail.com

O Vancouver B.C. – 2160 Cambia St – Vancouver BC V5Z 4T1 Ph 604-558-4941 F 604-425-1405

Email: oralmedicine@atlantisdental.ca