

University of Saskatchewan College of Dentistry General Practice Residency

Oral Medicine-Oral Pathology Clinic Referral Form

(Dr. Amanda Gruza, DMD, FRCD(C))

Fax Referrals To: (306) 966-1795 Radiographs/Clinical Images can be sent directly to amanda.gruza@usask.ca

REFERRING DENTIST/PHYSICIAN/SPECIALIST:

Name:		
Address:		
Phone:		·
	PATIENT INFORMATION:	
Name:		
Age:	Male/Female/Other	
Address:		
Phone:		
Cell:		
PHN:		



PATIENT MEDICAL HISTORY:

cheek	Conditions:		
REASON FOR REFERRAL: Oral mucosal lesion (evaluation +/- biopsy) Follow up of precancerous lesion or site of previous oral cancer Oral manifestation of systemic disease or medication reaction Dry mouth or other salivary gland disorder Temporomandibular disorder Orofacial pain Dental sleep medicine (oral appliances for obstructive sleep apnea) Consultation regarding dental management of medically compromised patient (including oncology and organ transplant patients)	Medications:		
Oral mucosal lesion (evaluation +/- biopsy) Follow up of precancerous lesion or site of previous oral cancer Oral manifestation of systemic disease or medication reaction Dry mouth or other salivary gland disorder Temporomandibular disorder Orofacial pain Dental sleep medicine (oral appliances for obstructive sleep apnea) Consultation regarding dental management of medically compromised patient (including oncology and organ transplant patients)	Allergies:		
labial much longue tongue tong	 Oral mucosal lesion (evaluation) Follow up of precancerou Oral manifestation of syst Dry mouth or other saliva Temporomandibular disor Orofacial pain Dental sleep medicine (or Consultation regarding de 	is lesion or site of previous temic disease or medication ry gland disorder order ral appliances for obstructed ental management of med	ion reaction tive sleep apnea)
97654221 12245670	hard palate soft palate		floor of mouth dudys (lingual) (buccal)
8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8		8 7 6 5 4 3 2 1	12345678