# Oral Medicine Consultation
# Referral Form

Division of Oral Medicine and Dentistry
Brigham and Women's Hospital
45 Francis Street, Boston, MA 02115
Tel: 617-732-6974
Fax: 617-264-6312

Refer to: Specific provider (please identify) ___________ First available provider____

**Referring Doctor Information**: (Please fill out completely so we can send you a consultation note)

Name: ________________________________________________

Address: ________________________________________________

Tel No: ____________________ Fax No: ______________________

Email: __________________________

---

**Patient Information**:

Name: ____________________________________ Date of Birth: _____________

Telephone: Home: ____________________ Work: ________________________

Cell : _____________________ Best time to call: ________________

Nature of condition: ____________________________________________

______________________________________________________________

______________________________________________________________

**Please direct the patient to call the BWH Patient Service Center at 866-489-4056 to register and obtain a medical record number. Patient must register with BWH before an appt can be made.**

Please send any pathology reports and/or radiographs with the patient, if applicable. A consultation report will be sent to you within 1-2 weeks of the patient's visit.