



Northwest Center for Oral and Facial Surgery

6222 NE 74th Street, Box 354916

Seattle, WA 98115

PH: 206-543-5860, FAX: 206-616-7251

Date of referral: \_\_\_\_\_

**IMPORTANT Radiology: Originals preferred for film images. Digital images must be of diagnostic quality.**

1. \*E-mail all x-rays in advance to [nwcofs@uw.edu](mailto:nwcofs@uw.edu)
2. Referrals can be mailed, faxed, or sent by \*email to [nwcofs@uw.edu](mailto:nwcofs@uw.edu)
3. Patients may hand-deliver the referral at the time of their appointments

For questions please call 206-543-5860 or send an email to [nwcofs@uw.edu](mailto:nwcofs@uw.edu).  
Visit [nwface.org](http://nwface.org) for more information about our services.

\*Please consult our [referral email policy](#)

**WE REQUIRE THE COMPLETION OF ALL FIELDS IN ORDER TO PROCESS IN A TIMELY MANNER**

**PATIENT INFORMATION**

Patient Name		Date of Birth	
Address (street, city, state, and zip code)			
Home Phone		Cell Phone	
Medical Insurance (please list)		Dental Insurance and Provider One ID #	
Guardian or Power of Attorney	Contact Person Name	Contact Person Home Phone	Contact Person Cell Phone

**REFERRAL INFORMATION**

Reason for Referral: (list each tooth number individually and please use Tooth Chart)		
Referred By (provider and facility name)	Provider Phone	Provider Fax
Address (street, city, state, and zip code)		Provider E-mail



Primary Physician Name		Office Phone	Office Fax
Address (street, city, state, and zip code)			Office E-mail
Primary Medical Diagnosis	Other Medical Conditions, including phobias		List All Medications
Wheelchair Bound: <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, able to transfer from wheelchair?: <input type="checkbox"/> YES <input type="checkbox"/> NO			Oxygen Tanks: <input type="checkbox"/> YES <input type="checkbox"/> NO

**PATIENT RECORDS**

If UWMC or HMC Patient – Medical Record Number:	Date of Last Complete DENTAL Exam	<b>Please attach copy of Medical and Dental workup to this form.</b>
Current X-Rays: <input type="checkbox"/> Pano <input type="checkbox"/> Ceph <input type="checkbox"/> PA <input type="checkbox"/> CT <input type="checkbox"/> MRI		