SCHOOL OF DENTISTRY
UNIVERSITY of WASHINGTON

Clear Form

Oral Surgery Student Clinic
1959 NE Pacific Street, D-251
Seattle, WA 98195-7134
PH: 206-616-6996
FAX: 206-685-6233
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 osclerk@uw.edu
2. Referrals can be mailed, faxed, or sent by *email to osclerk@uw.edu
3. Patients may hand-deliver the referral at the time of their appointments

For questions please call 206-616-6996 or send an email to osclerk@uw.edu.

*Please consult our referral email policy

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

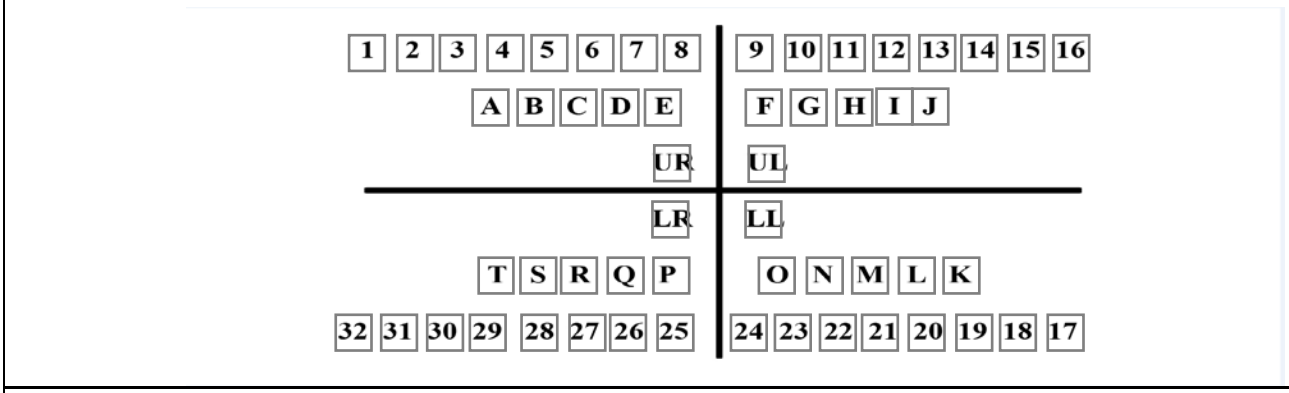
PATIENT INFORMATION

Patient Name			Date of Birth
Address (street, city, state, and zip code)			
Home Phone	Cell Phone		E-mail
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: YES NO If yes, able to transfer from wheelchair?: YES NO		Oxygen Tanks: ☐ YES ☐ NO

PATIENT RECORDS

If UWMC or HMC Patient – Medical Record Number:	Date of Last Complete DENTAL Exam	Please attach copy of Medical and Dental workup to this form.

Current X-Rays: ☐ Pano ☐ Ceph ☐ PA ☐ CT ☐ MRI