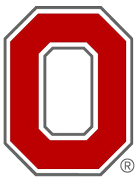

Ohio State
Dental Faculty
Practice

ORAL PATHOLOGY CONSULTANTS
PATIENT REFERRAL

Preferred Pathologist:

any available

Kristin K. McNamara, DDS, MS

Hiba Qari, BDS, MSc

Referred By:

Name: ______________________________

Facility: ______________________________

Phone: ______________________________

Patient Information:

Name: ______________________________

Date of Birth: ______________ Gender: M F

Address: ______________________________

____

Phone: ______________________________

Dental Ins.: ______________________________

Medical Ins.: ______________________________

ID#: ______________________________

Referral notes, x-rays:

Mailed on (Date)__________________________

Patient to bring to consult

E-mailed by secure email to DFPrecords@osu.edu on (Date)____________________________

Faxed to 614-292-4960 on (Date) ________________

Reason for Referral:

Specific concerns:

Significant Medical History (required):

Signature of Referring Provider: ______________________________ Date: ______________

Thank you for your referral.

Ohio State Dental Faculty Practice | Postle Hall, 2nd Floor | 305 West 12th Avenue | Columbus, Ohio 43210 Phone: 614-292-1472 | Option 2: Scheduling, Option 3: Insurance/Preauthorization
Fax: 614-292-4960 | Secure email: DFPrecords@osu.edu