THE OHIO STATE UNIVERSITY
COLLEGE OF DENTISTRY

Room 2045 Postle Hall
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PROSTHODONTICS PATIENT REFERRAL FORM

Date: _____

Patient first name:_____ Patient last name:_____

Date of Birth:_____

Patient address:_____

Patient phone: _____Cell phone:_____

☐ Full mouth rehabilitation ☐ Limited care ☐ Consultation

Fixed_____

Removable_____

Fixed/Removable_____

Implant therapy_____

Comments_____

Please return patient for general care to referring dentist. ◯ Yes ◯ No

Are there models available: ◯ Yes ◯ No

Radiographs:

◯ Enclosed ◯ Patient will bring ◯ None provided ◯ Will be sent ◯ On Axium

To transfer patient records and radiographs electronically, please e-mail them to advancedpros@osu.edu

Please include your office name/phone number, patient name/date of birth and date of radiographs

Referring Dentist:_____

Address:_____

Telephone:_____ E-mail:_____

Please email this form to advancedpros@osu.edu, or fax to 614-688-8688.