Physician Referral Form

EMORY HEALTHCARE

Please provide the following so we can schedule an appointment:

○ PERTINENT MEDICAL RECORDS ○ IMAGING ○ INSURANCE AUTORIZATION (IF REQUIRED)

Patient information

Patient name: ○ M ○ F

Street address:

City, state: Date of birth:

Parent/guardian:

Please check preferred contact phone number:

○ HOME: ○ CELL: ○ WORK:

Interpreter needed? ○ YES ○ NO Language:

Primary Care Provider (IF DIFFERENT FROM REFERRING):

This visit is (MARK ONE):

○ **Routine** WITHIN 30 DAYS ○ **Semi-urgent** *WITHIN 2 WEEKS ○ **Urgent** *LESS THAN 48 HOURS

*For urgent appointments, please call 404-778-4500

I am requesting: ○ CONSULT ONLY ○ ONGOING CARE ○ REFERRAL REQUESTED BY PATIENT

With surgeon: ○ Dr. Steven Roser ○ Dr. Gary Bouloux ○ Dr. Shelly Abramowicz ○ Dr. Stephanie Drew

Please Evaluate for the following:

○ Extraction of Teeth (please indicate below): ○ Exposure and Bracketing (please indicate below):

○ Implants (please indicate below):

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
			A	B	C	D	E	F	G	H	I	J			
			T	S	R	Q	P	O	N	M	L	K			
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

○ Orthognathic Surgery ○ TMJ Pain/Dysfunction

○ Pathology ○ Radiographs

○ Nerve Injury ○ Sleep Apnea

○ Facial Trauma ○ Other: _____

Radiographs or Clinical Photos: ○ E-Mailed ○ Given to Patient ○ Please Take ○ No X-Ray

Referring provider information

Name: Clinic:

City, state: Phone no.:

Fax: Email:

Office contact:

Please note:

Except for emergencies, the first appointment is for a consultation and evaluation only. Procedures to be performed will be discussed at the time of consultation, and a surgery date will then be scheduled.

Many insurance companies require a written referral from the primary care physician. Please make sure we receive the referral prior to scheduling, or the patient's insurance company may refuse to pay for services.

QUESTIONS ABOUT THIS REFERRAL? CALL US AT 404-778-4500.