University of California
San Francisco
UCSF
Fresno Medical Education Program
ORAL & MAXILLOFACIAL SURGERY

ROBERT S. JULIAN III, DDS, MD, INC.
BRIAN M. WOO, DDS, MD, INC.
GEORGE M. ZAKHARY DDS, MD. INC.
CRMC – Ambulatory Care Center
290 N. Wayte Lane 2400 Fresno, CA 93701
Phone: (559) 459-4101 * Fax: (559) 459-5744

CONSULTATION REFERRAL FORM

Date: _____

Patient's Name: _____ DOB: _____

Address: _____ City/State/Zip: _____

Home Phone Number: _____ Work/Cell/Other: _____

Appointment: _____ at _____ _____
Date Time Primary Language

Referring Provider (full name please): _____

Address & Zip Code: _____

*** Referring Provider NPI (REQUIRED): _____ ***

Referring Provider Fax #: _____ Office #: _____

Office e-mail: _____

Please Circle requested treatment and add any necessary details.

1) Referred for Extraction of Teeth indicated below:

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
Right	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	Left

Right	A	B	C	D	E	F	G	H	I	J	Left
	T	S	R	Q	P	O	N	M	L	K	

Other Instructions: _____

_____

2) Maxillofacial Fractures: _____

3) Maxillofacial Cyst/Tumor: _____

4) Head/Neck Cancer: _____

5) Orthognathic Surgery: _____

6) Pre-prosthetic Surgery: _____

7) Biopsy: _____

8) Implants: _____

9) Nasal Surgery: _____

10) Cleft Lip/Palate - Craniosynostosis: _____

Radiographs Available: ☐ Yes ☐ No Report Available: ☐ Yes ☐ No

INSURANCE COVERAGE: **Please include copies of ALL billing information**

Dental Coverage: ☐ Yes ☐ No * Medical Coverage: ☐ Yes ☐ No**
If yes, please fax copy of ALL Insurance information to: (559) 459-5744