

Tufts Oral Pathology Services
Clinical Referral Form



Clinical oral pathology referrals are seen by:

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Laboratory Director, Tufts Oral Pathology Services
Diplomate, American Board of Oral and Maxillofacial Pathology

Patient Information

Patient's Name: _____ DOB: _____

Address: _____

Telephone: _____ Medical Insurance Carrier: _____

Referring Clinician Information

Referred by: _____ Date of Referral: _____

Address: _____

Telephone: _____ Email: _____ Fax: _____

Reason for Referral (please be as specific as possible):

Information to be Submitted to Tufts

Please **email, mail, and/or fax*** this **completed Referral Form AND the patient's relevant medical records, including photographs and/or radiographs to Tufts.**

*Clinical notes and referral forms may be faxed; however, please only send photographs or radiographs by email or mail.

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