H O W
T O
R E F E R

Thank you for your referral! Please complete this page and trifold and mail, or fax ATTN: Nikki Guerrettaz (fax 317 278 3018). Please make sure to **include all patient contact information**, so we can then contact your patient to set up an appointment. **Referral from:**

DERMATOLOGY, INC.

(please circle referring doctor name)

Christopher M. Bohyer, MD
Ryan K. Brashear, MD
Robert H. Huff, MD
William B Moores, MD
Chistoper G. Rehme, MD
Keeter D. Sechrist, MD
Kirsten M. Turchan, MD
Brian J. Williams, MD
Veneda Robinson, NP ~ Mary Tempel, NP

1801 North Senate, Suite 745
Indianapolis, Indiana 46202
PH 317 926 3739; FAX 317 475 6133

Please note: In general, oral mucosal lesions that have not resolved in two weeks should be biopsied or referred for biopsy. If you would like a CODT doctor to view a biopsy and recommend treatment prior to your patient being seen at CODT, please submit biopsy to Oral Pathology Group (you may contact Jenny Robison at 317 274 7668 for supplies and info).

DERMATOLOGY INC
1801 N SENATE
STE 745
INDIANAPOLIS IN 46202

The Center for Oral Diagnosis & Treatment
at the IU SCHOOL OF DENTISTRY
1121 WEST MICHIGAN STREET
ROOM S110, *Nikki Guerrettaz*
INDIANAPOLIS, INDIANA 46202

Helping you and your patients handle oral medicine problems ..

We would like to refer:

Patient name:_____

Today's date:_____

Male **Female** (circle one)

Date of birth:_____/_____/_____

Address:_____

City, State, Zip:_____

Home Phone #:_____

Work Phone #:_____

Other Contact #:_____

Reason for referral:_____

_____

_____

Past treatment for this problem ***(please fax or mail additional records, radiographs or referral letters that you would also like us to see)***:___

_____

_____

_____

_____

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