UCSF Health

How to refer to the UCSF Oral Dysplasia Program

For all referrals, **complete the back side of this form** and submit to:
Attn: Oral Dysplasia New Patient Coordinator
Fax (new referrals): 415-502-8180
Fax (existing referrals): 415-885-7711
For any questions, call: 415-476-5903

When to refer

Please use this helpful checklist to determine if a referral to the UCSF Oral Dysplasia Program is appropriate:

Does the patient have undiagnosed white and/or red lesions in/on the mouth, tongue or lips?	☐ Yes	☐ No
Does the patient have white and/or red lesions associated with cigarette smoking or smokeless chewing tobacco in/on the mouth, tongue or lips?	☐ Yes	☐ No
Does the patient have a prior diagnosis of oral dysplasia or cancer?	☐ Yes	☐ No
Is the patient at high risk for developing oral cancer (e.g. history of solid organ or hematopoietic stem cell transplant, genetic disorders such as Fanconi anemia or dyskeratosis congenita, etc.)?	☐ Yes	☐ No

▶ **If you answered "Yes" to any of the above,** your patient should be seen by the specialists at the Oral Dysplasia Program for further evaluation. Please complete the backside of this form to refer your patient.

Although not required, the following are extremely helpful in expediting the referral process for your patient to provide them with the necessary care. If available, please submit the following with your referral:
☐ Prior biopsy reports, which can help avoid delays in treatment
☐ Pertinent clinical photographs
☐ Relevant clinic notes, especially if any prior treatments were performed
☐ Specific concerns or questions you would like our team of providers to address

▶ **If you did not answer "Yes" to any of the above,** consider referral to the
UCSF Sol Silverman Oral Medicine Clinic:
513 Parnassus Ave., Seventh Floor, Room S-722
San Francisco, CA 94143-0658
Phone: 415-476-2045
Fax: 415-514-2862

If you are unsure about whether to refer your patient or have any questions, including any clinical issues or clarifications, please call us at 415-476-5903 and our staff will be happy to assist you.

Thank you! We look forward to working together to provide excellent care for your patients.

UCSF Health

Referral Form

Thank you for choosing to refer your patient to us. To start the referral process, please complete this form and **fax it to (415) 502-8180.**

- Include brief, pertinent medical records, including test results and imaging, that support the consultation.
- Include patient's insurance card (both sides) and HMO authorization if required.

If you require additional assistance, please call the Oral Dysplasia Program at (415) 476-5903.

Date: _____ From: _____

No. of pages: _____ Title: _____

To UCSF practice: Oral Dysplasia Program Phone: _____

Fax: (415) 502-8180 Fax: _____

Patient Information

Name of patient: _____

DOB: _____

Home phone: _____ ☐ Work or ☐ cell phone: _____

Parent or Caregiver: _____

Address: _____

City: _____ Zip: _____

Insurance: Include patient's insurance card (both sides) and HMO authorization if required

Consultation Request Information

Diagnosis/ICD9/10: _____

Name of UCSF Physician (if known): _____ Specialty: _____

Reason for consultation: _____

By providing the information requested and signing below, you agree that we may initiate treatment following consultation or perform medically necessary diagnostics, in association with this consultation. We look forward to collaborating with you on your patient's treatment plan.

Referring Physician Information

Referring Physician: _____ Specialty: _____

Phone: _____ Fax: _____

PCP name: _____ Phone: _____

Signature: _____

Updated November 2019