WVU Dental

**PATIENT REFERRAL FORM**
**EMAIL FORM TO: SODReferrals@hsc.wvu.edu**

**Referred From:** _____ **Referred To:** _____

**Patient Name:** _____ **Parent/Guardian:** _____
**Birthdate:** _____ **Telephone:** _____
**Address:** _____ **Email:** _____
**Telephone:** _____

**REASON FOR REFERRAL (complete as appropriate)**

☐ **CONSULTATION RE:** _____

☐ **TREATMENT: Please provide details of requested service(s):**

**RELEVANT HISTORY:**
**(note any special problems, conditions, or considerations relevant to diagnosis and treatment)**

**PLEASE INCLUDE ANY CURRENT, DATED IMAGES.**

**SIGNED:** _____ **DATE:** _____

**WE APPRECIATE YOUR REFERRAL**