**REFERRAL TO ORAL AND MAXILLOFACIAL PATHOLOGY**

☐ **CARL M. ALLEN, DDS, MSD**

☐ **ASHLEIGH BRIODY, DDS**

☐ **BIOPSY ALSO REQUESTED**

☐ **FIRST AVAILABLE**

Central Ohio Skin & Cancer, Inc.
300 Polaris Pkwy, Suite 3300, Westerville, OH 43082
Phone: 614-898-7546 Fax: 614-794-4294

**PATIENT NAME**: _____ DOB: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

INSURANCE PROVIDER: _____

**(Please provide a photocopy of insurance card, front and back. Please note that COSC is not a provider for any Medicaid programs.)**

**REASON FOR REFERRAL/CLINICAL SYMPTOMS & DURATION:**

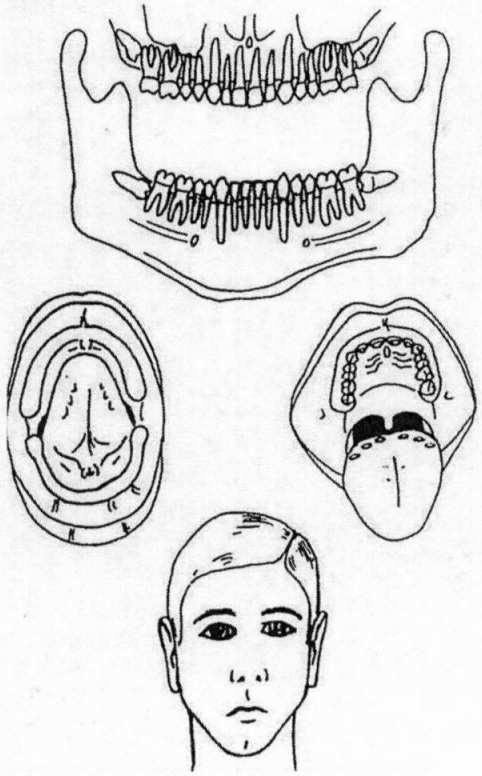
**SITE**

**SIZE:**

☐ **RADIOGRAPHS PROVIDED**

☐ **CLINICAL PHOTOS PROVIDED**

☐**ENCLOSED** ☐**EMAILED TO**: DrCarlAllen@cohskin.com



**REFERRING PHYSICIAN**: _____

PHONE#: _____ FAX#: _____