REFERRAL TO ORAL AND MAXILLOFACIAL PATHOLOGY

- ☐ **CARL ALLEN, DDS, MSD**
- ☐ **ASHLEIGH BRIODY, DDS, MS**
  - ☐ **BIOPSY REQUESTED**
  - ☐ **CO_2 LASER ABLATION**
  - ☐ **FRENECTOMY**
- ☐ **FIRST AVAILABLE**

Central Ohio Skin & Cancer, Inc.
430 Altair Parkway, Suite 210, Westerville, OH 43082
Phone: 614-898-7546 Fax: 614-794-4294

PATIENT NAME: ____DOB: __________________________

PATIENT PHONE NUMBER: ____

MEDICAL INSURANCE COMPANY:____

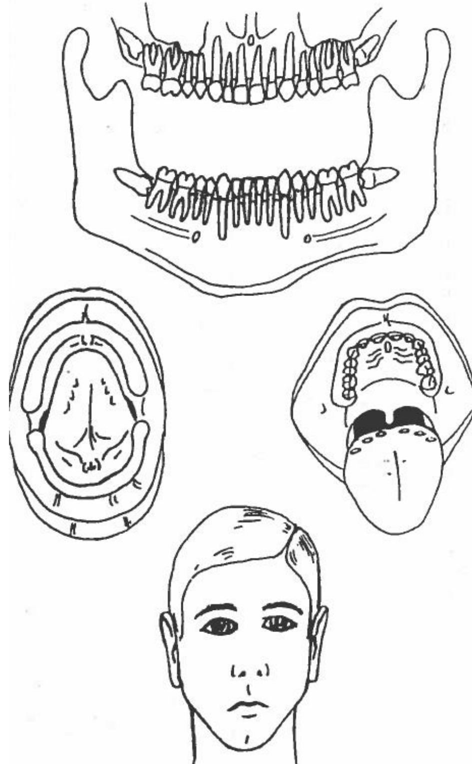
(Please provide a copy of medical insurance card, front and back. Please note that COSC is not a provider for any Medicaid.)

REASON FOR REFERRAL/CLINICAL SYMPTOMS & DURATION:

SITE:

SIZE:

- ☐ **RADIOGRAPHS PROVIDED**
- ☐ **CLINICAL PHOTOS PROVIDED**
  - ☐**ENCLOSED** ☐**EMAILED TO**: DrCarlAllen@cohskin.com



REFERRING PHYSICIAN: ____

ADDRESS: ____

PHONE#: ______________________________________ FAX#: ____