Oral Oncology and Oral Medicine Care Referral

PROVIDENCE Cancer Institute

1. Refer a patient via fax 971.282.0144 or email ORProvidence.specialtyclinic@providence.org
2. Email imaging, photos, scans and pathology reports to ORProvidence.specialtyclinic@providence.org

Patient Name: _____DOB:_____

Phone Number: _____Referring Provider:_____

ORAL LESION

Lesion location:

☐ Buccal or labial mucosa ☐ Gingiva ☐ Soft palate ☐ Hard palate ☐ Floor of mouth

☐ Tongue ☐ Throat ☐ Neck ☐ Skin of face ☐ Only on imaging (describe below)

Additional Info: _____

Lesion appearance: ☐ Ulcer ☐ Nodule ☐ Flat ☐ Multiple lesions

Other, please specify: _____

Lesion color: ☐ Pink ☐ Red ☐ White ☐ Red & White ☐ Pigmented/blueish

Lesion size: ☐ less than 1cm ☐ over 1cm

Pain level of lesion: ☐ Not painful ☐ Somewhat painful ☐ Extremely painful

How long has patient had lesion?_____

OROFACIAL PAIN

☐ TMD/TMJ ☐ Pain not responding to dental treatment ☐ Neuropathic pain ☐ Sleep apnea

ORAL ONCOLOGY

☐ Pre-treatment Onc. consult (dental clearance)
☐ Post-treatment complications
☐ Osteoradionecrosis, medication-related osteonecrosis
☐ Prosthetic reconstruction after cancer surgery
☐ Treatment side-effect management
☐ Trismus
☐ Oral mucosal concerns
☐ Post cancer orofacial pain

Other, please specify: _____

_____

Cancer Diagnosis:

☐ Active Tx ☐ Antiresorptive Medication (IVBP) ☐ Head and Neck Radiation (HNRT) ☐ Transplant

Please provide initial visit chart notes, treatment plan, and most recent office visit notes

Additional info: _____

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For questions, call our office: 503.215.1676