

Oral Oncology and Oral Medicine Care Referral

Office: 503.215.1676 – Fax: 971.282.0144

Email (imaging and scans): 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: _____