EASTMAN
INSTITUTE FOR ORAL HEALTH

UNIVERSITY of ROCHESTER MEDICAL CENTER
Medicine of the Highest Order

PROSTHODONTIC DEPARTMENT
(PROSTHODONTIC PROGRAM & IMPLANT SURGERY FELLOWSHIP PROGRAM)
REFERRAL FORM

625 ELMWOOD AVENUE, ROCHESTER, NY 14620
TEL: (585) 275-1147 FAX: 585-276-2941
EMAIL: edc_recordroom@urmc.rochester.edu

Date: _____

Referring Doctor's Information

Name: _____Facility Name: _____

Telephone: _____ Fax: _____

Patient's Information

Patient Name: _____DOB: _____

Primary phone number: _____

Parent/Guardian Name: _____

Reason for referral:

- ☐ Full Mouth Evaluation
- ☐ Implant Reconstructions
- ☐ Implant Placement & Site Development
- ☐ Crown and Bridge
- ☐ Aesthetic Dentistry
- ☐ Complete Dentures
- ☐ Removable Partial Dentures
- ☐ Maxillofacial Prosthetics
- ☐ Sleep Apnea Appliance
- ☐ Other:_____

Recent Radiographs:

- ☐ Accompany Patient
- ☐ Faxed
- ☐ Patient does not have recent radiographs
- ☐ Emailed (edc_recordroom@urmc.rochester.edu)

Comments:_____

Visit our website for more details: https://www.urmc.rochester.edu/dentistry/education/prosthodontics.aspx