Complete and print or save.

MAYO CLINIC

Patient Referral

Mayo Clinic Dental Specialties

Reset Form

Instructions: Complete and fax this form to 507-284-8082 or email as an attachment with radiographs to mndentaleexrays@mayo.edu

Phone: For all specialties, call us at 507-284-2850 Mon.–Fri., 8 am to 5 pm.

For Emergency Treatment: Call us during regular business hours. All other hours, call Saint Marys Emergency Department at 507-255-5591.

Mayo Clinic Staff Instructions:

TO BE SCANNED Form content retained in medical record. **Route to HIMS Scanning.**

Date *(mm-dd-yyyy)*	Referring Provider Name *(First, Middle, Last)*			
Referring Provider Street Address				Phone
City	State	ZIP Code	Email	
Patient Name *(First, Middle, Last)*				Birth Date *(mm-dd-yyyy)*
Patient Street Address				Sex ☐ Male ☐ Female
City	State	ZIP Code	Phone	Mayo Clinic Number

Select specialty or multiple specialties for this referral, your indication(s) for referral, and answer all applicable questions.

☐ Orthodontics

- ☐ Orthodontics only
- ☐ Orthodontics with potential surgical needs (for example, tooth extraction, jaw asymmetry)
- ☐ Orthodontics with potential restorative needs (for example, missing teeth, pre-prosthetic treatment)
- ☐ Orthodontics with potential sleep disordered breathing concerns

☐ Periodontics

- ☐ Tooth extraction/Bone grafting
- ☐ Dental implants
- ☐ Gingival/Soft tissue grafting
- ☐ Periodontitis
- ☐ Other (crown lengthening, biopsy, etc)

Yes	No	
☐	☐	Is antibiotic prophylaxis needed?
☐	☐	Does the patient have any heart issues?
☐	☐	Is the patient on blood thinners or medications for osteoporosis?

Implant Referrals Only

- ☐ Nobel Biocare™ (Branemark)
- ☐ Straumann®
- ☐ Implants to be restored at Mayo Clinic

☐ Prosthodontics

- ☐ Complete edentulism
- ☐ Partial edentulism
- ☐ Maxillofacial prosthetics
- ☐ Maxillofacial trauma
- ☐ Craniofacial/Congenital defect
- ☐ Severe attrition/Erosion
- ☐ Head and neck cancer/Oral cancer reconstruction

☐ Dental Sleep Medicine (Patient **must** have a diagnosis from a Sleep Medicine Provider.)

- ☐ Obstructive sleep apnea
- ☐ Primary snoring

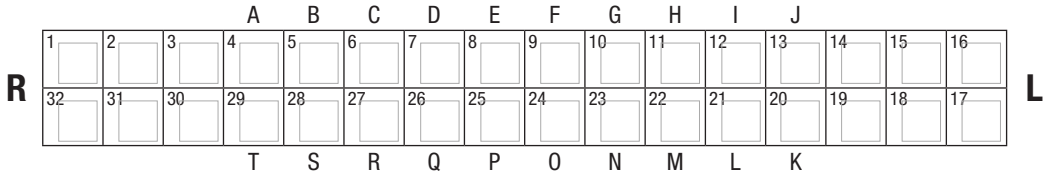
Yes	No	
☐	☐	Has the patient been evaluated by a Sleep Medicine Provider?
☐	☐	Has the patient completed an overnight sleep study?

Additional Information

We request all current x-rays be sent with referral. Select enclosed radiographs:

☐ Periapical(s) ☐ Bitewings ☐ FMX ☐ Panoramic

Indicate Location(s)



Save

Print