INDIANA UNIVERSITY

SCHOOL OF DENTISTRY

Orofacial Pain Patient Referral Form

To: **Dr. Massimiliano Di Giosia**

Date: _____

Patient Name	DOB
Address	Primary Phone #
Patient Email	Insurance Information:

Reason for Referral *(Please forward applicable patient documents along with this referral.)*

History of Presenting Complaint:

Past Treatments:

Imaging:

Please indicate imaging procedures that have been performed prior to the date of referral.

☐ MRI Date _____

☐ CT/CBCT Date _____

☐ Panorex Date _____

☐ Other (list) Date _____

Referring Provider	Referral NPI (*Required to Bill Medicare*)
Address	Referral Email
	Referral Phone #
	Referral Fax #

IU School of Dentistry Orofacial Pain, 550 University Blvd, UH-3195 Indianapolis, IN 46202

Email: madigi@iu.edu *Phone:* (317) 274-8300 *Fax:* (317) 274-0965