SUMMIT
ORAL & MAXILLOFACIAL SURGERY™

# NICOLETTE ESSIAN, DMD, CFNC, MS
ORAL & MAXILLOFACIAL PATHOLOGIST

## PATHOLOGY REFERRAL FORM
**YOU MUST BRING THIS TO YOUR CONSULTATION**

·Please send any recent xrays/images via email·

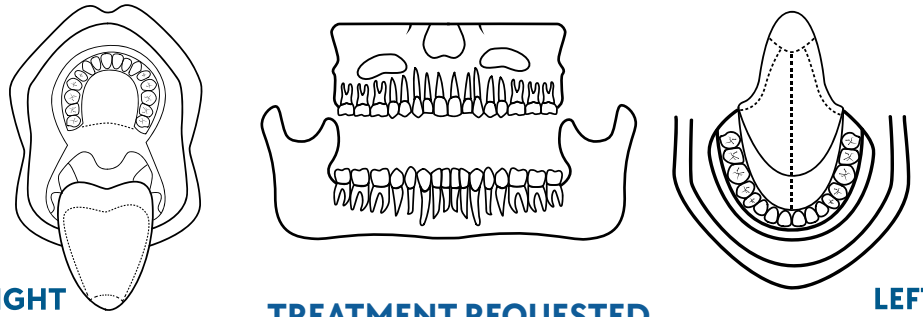
Patient's Name: _____

DOB: _____ Today's Date: _____

Referred By: _____

Referral Address: _____

·Please Circle The Area To Be Treated/Evaluated·



RIGHT LEFT

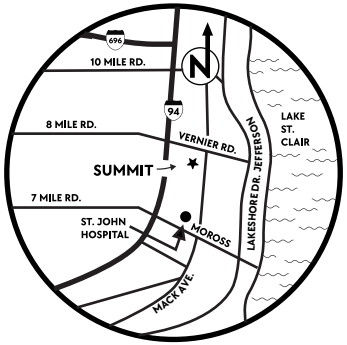
## TREATMENT REQUESTED

- ◯ Laser Ablation (Rochester Location) (Biopsy Proven Dysplasia)
- ◯ Consultation Based Management
- ◯ TMJ Evalulation/Botox
- ◯ Lesion Evaluation
- ◯ Biopsy
  - Location _____
  - Size _____
  - Symptoms _____
  - Duration _____
- ◯ Comments/Other:

·Please have your insurance info ready when scheduling your appointment·
·CHILDREN UNDER 18 MUST BE ACCOMPINIED BY A PARENT OR LEGAL GUARDIAN·
**www.summitfacial.com**

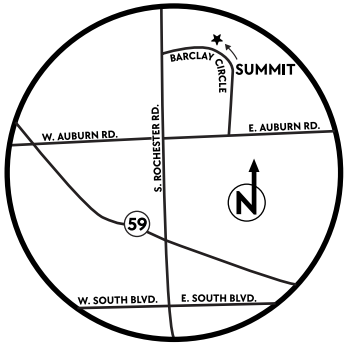
# PROVIDING **SPECIALIZED ORAL PATHOLOGY CARE** AT THESE **LOCATIONS**:

## GROSSE POINTE DETROIT



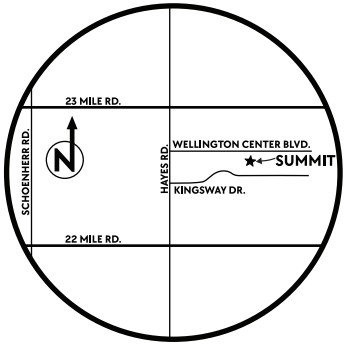

**ADDRESS:** 20675 Mack Ave.
Grosse Pointe Woods, MI 48236
**PHONE:** 313-885-8344
**FAX:** 313-885-1819
**EMAIL:** GP@SUMMITFACIAL.COM

## ROCHESTER TROY




**ADDRESS:** 305 Barclay Circle Dr. · #1000
Rochester Hills, MI 48307
**PHONE:** 248-293-5500
**FAX:** 248-293-5505
**EMAIL:** ROCH@SUMMITFACIAL.COM

## MACOMB CLINTON TOWNSHIP




**ADDRESS:** 15286 Wellington Center Blvd.
Macomb, MI 48044
**PHONE:** 586-286-1600
**FAX:** 586-286-8963
**EMAIL:** MAC@SUMMITFACIAL.COM