KINGDOM OF SAUDI ARABIA

Ministry of Higher Education

KING ABDULAZIZ UNIVERSITY

FACULTY OF DENTISTRY

University Dental Hospital

UDH
مستشفى الأسنان الجامعي
University Dental Hospital

المملكة العربية السعودية
وزارة التعليم العالي
جامعة الملك عبد العزيز
كلية طب الأسنان
مستشفى الأسنان الجامعي

ORAL & MAXILLOFACIAL PATHOLOGY & DIAGNOSTIC LABORATORY

CONSULTATION CASE REQUEST FORM

SUBMITTED BY:

1. **Patient or Relative** ☐

Patient Name: _____ **Date of Birth:** _____

Patient ID: _____ **Phone#:** _____

(If related) Relative name: _____ **Relationship to patient:** _____

Signature of submitter _____ **Date** _____

2. **Clinician** ☐

Clinician's Name: _____ **Phone#:** _____

Patient Name: _____ **Date of Birth:** _____

Patient ID: _____ **Phone#:** _____

Signature of submitter _____ **Date** _____

3. **Other** ☐

Name: _____ **Job:** _____ **Phone#:** _____

Patient Name: _____ **Date of Birth:** _____

Patient ID: _____ **Phone#:** _____

Signature of submitter _____ **Date** _____

Comments: _____

FOR LABORATORY USE ONLY

Received by: _____ **Date:** _____