THE OHIO STATE UNIVERSITY
NISONGER CENTER

Referral Form

Date: _____

Name:_____
Address:_____
City, State, Zip: _____
Phone Number: _____
Date of Birth: _____

Referred To: **ADULTS (18+ years)**
The Ohio State University
Nisonger Dental Program
345 McCampbell Hall
1581 Dodd Drive, 3rd FL
Columbus, OH 43210
Phone: (614) 685-3197
Fax: (614) 685-3212
Email: NisongerDental@osumc.edu

Referred To: **PEDIATRICS (0-18 years)**
The Ohio State University
Nisonger Dental Program
2879 Johnstown Road
Columbus, OH 43219
Phone: (614) 342-5795
Fax: (614) 342-5804
Email: Stacey.Grubb@osumc.edu

Referring Source:_____

Reason for Referral:
_____

_____

Significant Medical History:
_____

_____

What helps this person have a safe, enjoyable dental appointment?
_____

_____

When afraid or anxious, how does this person usually respond?
_____

_____

For referrals to our adult program: please email all current x-rays to:
NisongerDental@osumc.edu
Thank you!