Oral & Maxillofacial Surgery
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Referral Form

Patient's Name: _____ Date: _____
First Name Last Name

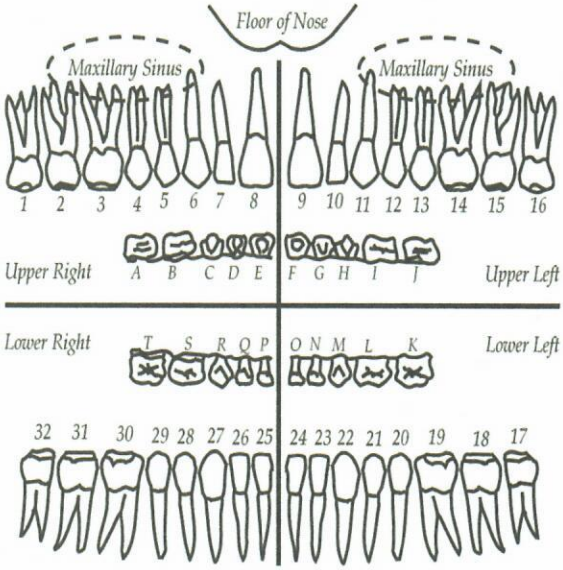
Date of Birth: _____ Phone: _____

☐ Patient to call & schedule appointment
☐ Please call patient to schedule appointment

Reason for Referral:

☐ Third Molar Evaluation ☐ Tooth Extraction(s)
☐ Pathology Evaluation/Biopsy ☐ Implant Evaluation
☐ Other _____

* If you are scheduled for Intravenous anesthetic, do not eat or drink anything for 6 hours before appointment.



Mark (x) for Extraction

Please Evaluate For Possible

☐ Bone Graft ☐ Soft Tissue Graft
☐ Sinus Lift ☐ Alveolar Ridge Distraction
☐ Vestibuloplasty ☐ Other _____

_____

_____

X-ray(s) Taken On:

_____ Mailed to Office _____ Given to Patient
_____ Please Take X-ray _____ None Available

ORTHOGNATHIC SURGERY

C.C. & Orthodontic Assessment

_____

_____

Maxillary Surgery

_____ LeFort 1 Osteotomy
_____ LeFort 1 Segmental
_____ Nasal

Mandibular Surgery

_____ Mandibular Advancement
_____ Mandibular Setback
_____ Chin Surgery

FACIAL PAIN & DYSFUNCTION

TMJ Dysfunction

_____ Nonsurgical
_____ Surgical Consultation

ADDITIONAL COMMENTS : _____

_____

_____

Referring Doctor _____ **Phone** _____ **Date** _____