

Referral for Surgical Opinion/Treatment

Dear Kevin,

I wish to refer to you: _____

Address: _____

Telephone: _____ D.O.B: _____

For: Consultation and treatment
Second opinion

Regarding: Extraction of the following tooth/teeth/root(s) _____
Implants to replace missing tooth/teeth

Implant/s to be restored by: _____

Or Mr Kevin Spencer to arrange restoration

Type of Implant preferred: _____

Facial Injury

Pathological lesion in mouth or jaw(s)

Orthognathic (Corrective Jaw) Surgery, Malocclusion

Comments:

Please Note: Radiographs enclosed Please arrange x-rays or Patient bringing x-rays
Indefinite Referral 12 Months

Referred by Dr: _____ Provider Number: _____

Address: _____

Email: _____ Phone Number: _____

Signature: _____

Date: _____ I agree to correspondence by email