OMFS ORAL AND MAXILLOFACIAL SURGEONS

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Referral for Surgical Opinion/Treatment

Dear David,

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) _____
- ☐ Exposure of the following teeth _____
- ☐ Implants to replace missing tooth/teeth
- ☐ 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

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