

## Referral for Surgical Opinion/Treatment

Dear Timothy,

I wish to refer to you: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ D.O.B: \_\_\_\_\_

For: Consultation and treatment

Other: \_\_\_\_\_

Regarding: Extraction of the following tooth/teeth/root(s) \_\_\_\_\_

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