REFERRAL FORM

ORAL MAXILLOFACIAL SURGERY

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DIPLOMATE AMERICAN BOARD OF ORAL & MAXILLOFACIAL SURGERY

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PATIENT INFORMATION

Date ***Referral Courtesy of*** ***Contact #*** ***Contact Email***

Patient Name: _____
Last *First* *M.I.*

Address: _____
Street Address *City* *Province* *Postal Code*

Phone: _____ / _____ Email: _____
Cell *Home*

Date of Birth: *M D Y* **Age.:** _____ **Sex:** M F X

Parent/Guardian if under 18: _____

Supplementary Health/ FNIHB Coverage: Y N #: _____

Special Considerations: Y N *if yes please circle* Difficulties with: Mobility Vision Hearing Other: _____

ORAL SURGERY INFORMATION

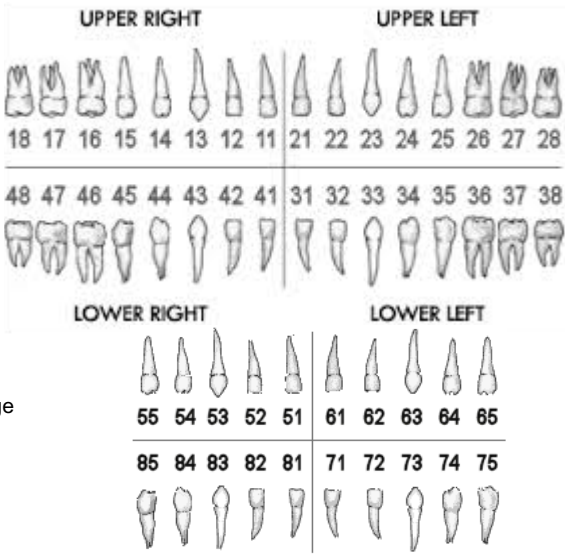
PROCEDURE/CONSULTATION NEEDED

☐ Extraction Teeth # _____

_____

☐ Dental Implant(s)	☐ All On 4/X	☐ Bone Grafting
☐ Orthognathic Evaluation	☐ Cleft Lip, Palate	☐ Distraction Osteogenesis
☐ Expose	☐ Expose, Bond	☐ Frenectomy
☐ TMJ Evaluation	☐ Biopsy	☐ Trauma
☐ Aveoloplasty	☐ Scar Revision	☐ Genioplasty/Chin Implant
☐ Botox	☐ Fillers for Defects	☐ Platysmoplasty
☐ Facial Lesions	☐ Apicoectomy	☐ Infection, Incision Drainage
☐ Other:		

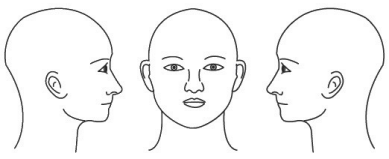
PLEASE "X" THE TEETH TO BE EXTRACTED



RADIOGRAPHS

Date of Radiographs: M D Y

☐ Enclosed ☐ Emailed ☐ Given to Patient ☐ Required



REFFERING DOCTOR'S COMMENTS:

_____

_____

_____

Referring Doctor's Signature: _____ **Date:** _____