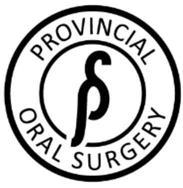


ORAL MAXILLOFACIAL SURGERY

REFERRAL FORM

DR. ROBERT WAGNER
DMD, MD, FRCD(C)
DIPLOMATE AMERICAN BOARD OF ORAL & MAXILLOFACIAL SURGERY

PROVINCIAL ORAL SURGERY
326 UNIVERSITY PARK DRIVE
REGINA SK S4V 0Y8
(306)359-7040
fax: (306)359-7044
Email: staff@provincialoralsurgery.com
www.provincialoralsurgery.com

PATIENT INFORMATION

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

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

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

Phone: ________ / ________ Email: ______________
Main *Alternate*

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: ____________

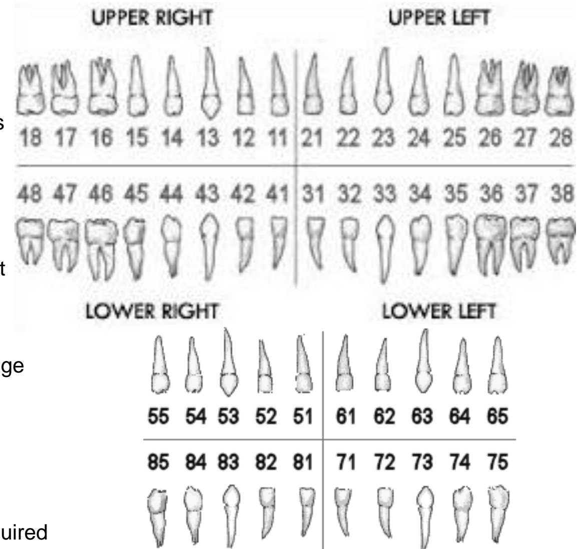
ORAL SURGERY INFORMATION

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:		

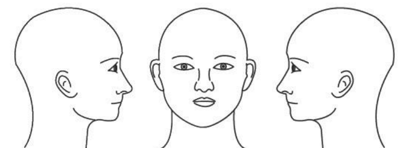
PLEASE “X” THE TEETH TO BE EXTRACTED



RADIOGRAPHS

Date of Radiographs: ___M ___D ___Y___

☐ Enclosed ☐ Emailed ☐ Given to Patient ☐ Required



REFFERING DOCTOR’S COMMENTS:

____

____

____

Referring Doctor’s Signature: ______________________________ **Date:**______________