



**ORAL SURGERY REFERRAL**

Patient Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Referring Dr: \_\_\_\_\_ Office: \_\_\_\_\_

- Please contact patient     Patient was instructed to contact your office

**REASON FOR REFERRAL:**

- Extract the teeth as indicated below     Perform I&D for infection  
 Evaluate for Implant placement     Perform biopsy as indicated  
 Evaluate for Bone graft/ridge augm     Evaluate lesion as indicated  
 Evaluate for Preprosthetic surgery     Evaluate for Soft tissue surg.  
 Evaluate for Orthognathic surgery     Evaluate TMJ/Orofacial pain  
 Evaluate for Oral/facial trauma     Expose & Bond # \_\_\_\_\_  
 Other \_\_\_\_\_

|    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| 1  | 2  | 3  | 4  | 5  | 6  | 7  | 8  | 9  | 10 | 11 | 12 | 13 | 14 | 15 | 16 |
| R  |    |    | A  | B  | C  | D  | E  | F  | G  | H  | I  | J  | L  |    |    |
|    |    |    | T  | S  | R  | Q  | P  | O  | N  | M  | L  | K  |    |    |    |
| 32 | 31 | 30 | 29 | 28 | 27 | 26 | 25 | 24 | 23 | 22 | 21 | 20 | 19 | 18 | 17 |

**ANESTHESIA & SEDATION:**

Patient would prefer to have procedure(s) performed with:

- IV Sedation     No sedation, Local anesthetic only  
 Nitrous oxide     Sedation was not discussed

**READINESS:**

- Wants to have treatment done ASAP  
 Interested in treatment, but not in a hurry  
 Unsure about treatment, needs more info

**RADIOGRAPHS:**

- Please take radiographs as needed  
 Will send by email

**SPECIAL INSTRUCTIONS:**

\_\_\_\_\_