Oral & Maxillofacial Surgery Referral

Specialist Name: _____ Phone Number: _____

Address: _____ FAX Number: _____

_____ Appointment Date: _____

Patient Name: _____ Appointment Time: _____

Referring Doctor: _____ Phone Number: _____

CALL REFERRING DOCTOR BEFORE TREATMENT: YES ☐ / NO ☐

REMOVE:

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

INSTRUCTIONS/REMARKS:

CONSULTATION:

- ☐ Wisdom Teeth
- ☐ Apicoectomy
- ☐ Implants
- ☐ TMJ
- ☐ Other _____
- ☐ Orthognathic Surgery
- ☐ Pathology
- ☐ Snoring/Sleep Apnea
- ☐ Cosmetic Surgery

_____

Doctor Signature Date

INSTRUCTIONS

Complete and sign the referral form. Then send to the doctor via one of the following options:

1. Email: Fill out the form. Print.
   - Scan the completed form and save as a JPEG or PDF file.
   - Open your email client and attach the saved (scanned) document.
   - Send to the Office Email address.

2. Print the form. Then, Fax it to the doctor's office (fax number on page 1 of this form or on the DSI website).

3. Print the form. Then, Mail it to the doctor's office (address on page 1 of this form or on the DSI website).

4. Print the form. Give to the patient to deliver to the doctor's office.