



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					
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	L				
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INSTRUCTIONS/REMARKS: _____

CONSULTATION:

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

Doctor Signature _____ Date _____

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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.