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ORAL SURGERY REFERRAL FORM

Patient Name _____ Date _____

Appointment Date _____ Time _____

Referred by Doctor _____

- ☐ Extractions #: _____
- ☐ 3D Cone Beam CT Scan
- ☐ Bone Grafting/ Sinus Lift
- ☐ Implants #: _____
- ☐ TMJ/Orofacial Pain Evaluation
- ☐ Apicoectomy, Tooth # _____
- ☐ Pathology/ Biopsy
- ☐ Maxillofacial Infection
- ☐ Maxillofacial Trauma
- ☐ Laser Treatment of Snoring
- ☐ Laser Treatment of Facial Skin Lesions
- ☐ Conscious Sedation with Nitrous Oxide (Laughing Gas)
- ☐ Other _____

REMARKS _____

_____

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

A B C D E F G H I J

RIGHT _____ LEFT

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

INSTRUCTIONS: ONLY FOR PATIENTS RECEIVING IV SEDATION

1. **DO NOT EAT OR DRINK ANYTHING** for at least six hours before surgery.
2. Make arrangements to have someone drive you home following surgery.

Minors (under 18 years) must have parent or guardian present at time of surgery.

PLEASE BRING THIS CARD WITH YOU