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ORAL SURGERY REFERRAL FORM

Patient Name: _____ Phone No: _____
Referring Doctor Name: _____Phone No: _____
Address:
_____

Reason for Referral:

- Surgical Removal of Erupted Tooth
- Soft Tissue Impaction Tooth # _____
- Partial Bony Impaction Tooth # _____
- Full Bony Impaction Tooth # _____
- Surgical Removal of Root Tip _____
- Bone Graft
- Implants
- Removal of Tori UR UL LR LL
- Biopsy
- Frenectomy
- Alveoplasty
- Consultation for Cosmetic Surgery

Teeth to be Extracted

A B C D E | F G H I J
Patient's Right 1 2 3 4 5 6 7 8 | 9 10 11 12 13 14 15 16 Patient's Left
_____
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

Does patient require premedication? Yes No
Antibiotic used
_____
Any medical concerns requiring attention
_____

Radiographs

- Please take/send copy
- Patient will bring copy
- I will send / Please return

Referring Dentist's Recommendation:

_____
_____
_____
_____

Referring Dentist's signature: _____ Date: _____