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: _____