OMS Referral Form

PATIENT INFORMATION:

Today's Date _____

First Name _____ Last Name _____ Date of Birth _____

Parent / Guardian Name _____

Contact Telephone _____ Contact E-Mail Address _____

Does the patient require antibiotics prior to dental treatment? ❑ Yes ❑ No • ❑ Patient will call for appointment ❑ Please call patient

Treatment _____

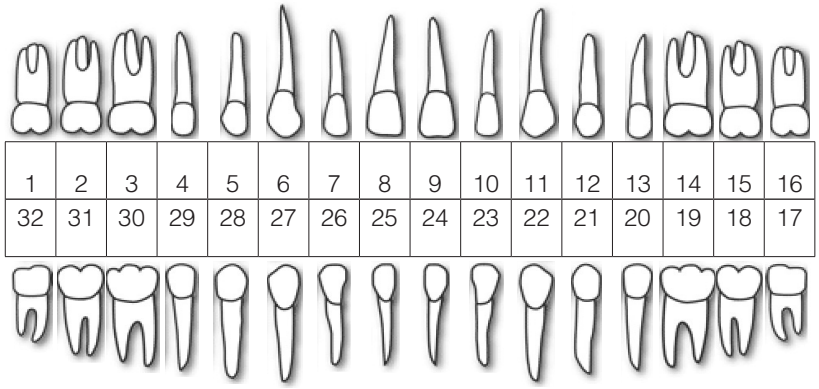
REFERRING DOCTOR'S INFORMATION:

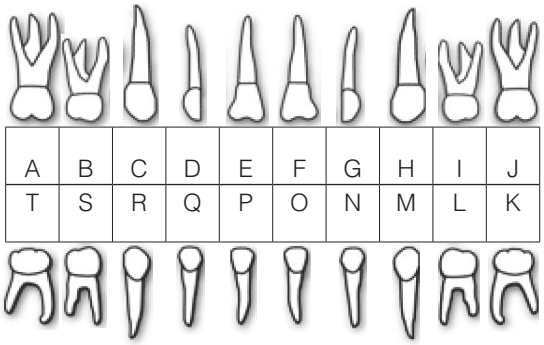
Referred By _____ Telephone _____

E-Mail Address _____

PROCEDURES:

❑ Extraction (see below)
❑ Alveoplasty
❑ Biopsy
❑ Incision & Drainage
❑ Lesion Evaluation
❑ Exposure
❑ Hard Tissue
❑ Infection
❑ Expose & Bond
❑ Soft Tissue
❑ Frenectomy
❑ Apicoectomy
❑ Other _____





Please Verify Teeth For Extraction _____

CONSULTATIONS:

❑ TMJ
❑ Implants: ❑ Immediate ❑ Delayed
❑ Orthognathic Evaluation
❑ Pre–Prosthetic
❑ Cleft Lip & Palate
❑ Cosmetic
❑ Ridge Augmentation
❑ Oral / Facial Lesion
❑ Bone Grafting
❑ Other

Implants:

Surgical Template:

RADIOGRAPHS OR CLINICAL PHOTOS:

❑ Being Mailed
❑ Given To Patient
❑ Please Take
❑ No X–Ray

TO ATTACH X-RAY(S) TO THIS REFERRAL FORM PLEASE SUBMIT THE FORM ABOVE OR BELOW.

AFTER THE FORM IS SUBMITTED YOU WILL THEN HAVE THE OPTION TO UPLOAD X-RAYS THAT WILL BE ATTACHED TO THIS REFERRAL FORM.

❑ Attached With This Referral; if X-Rays are attached, what date were they taken _____

CASE NOTES: