DR.GUTIERREZ
DR.STERK

ORAL & MAXILLOFACIAL SURGERY

OMFS Referral Form

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Date of Referral: ____

Referring Practice/ Doctor Name: ________________________________

Patient's Name: ______________________________DOB: ____________

Reason(s) for referral (check all that apply)

Dentoalveolar surgery:

☐ Extraction teeth #s: _________ ☐ Alveoplasty: _____________

☐ Incision and Drainage: _________ ☐ Apicoectomy: __________

☐ Biopsy: _____________ ☐ Expose and Bond: ______________

☐ Frenectomy:_________ ☐ Dentoalveolar trauma:___________

Dental Implants#:____________ Pathology/Biopsy:____________

Orthognathic Evaluation:_________________________________

TMJ Evaluation:_______________________________________

Cosmetic Facial Surgery:_________________________________

Are Radiographs Available: ☐ Attached / Will Mail ☐ Not Available

Medical History: ☐ Negative ☐ Significant: ________________

Special Needs: ______________________________________

Anesthesia Recommendations:

☐ Local anesthesia ☐ IV Sedation ☐ General anesthesia, operating room

Other Comments: _____________________________________

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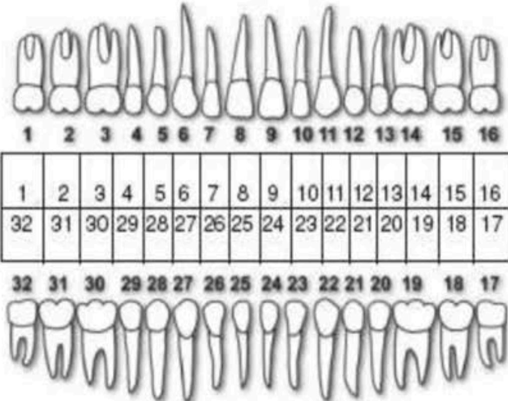
Please mark teeth to be extracted on diagram:



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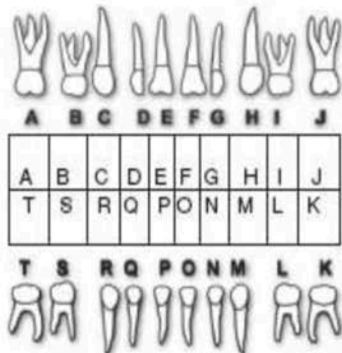

A	B	C	D	E	F	G	H	I	J
T	S	R	Q	P	O	N	M	L	K