Central Dental
COMPREHENSIVE DENTAL CARE

ORAL SURGERY REFERRAL FORM

Patient Name: _____ **Phone:** _____

Referring Doctor Name: _____ **Phone:** _____

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 *Tooth #* _____
- ❑ Bone Graft
- ❑ Implants
- ❑ Removal of Tori *Circle which applies:* **UR UL LR LL**
- ❑ Biopsy
- ❑ Frenectomy
- ❑ Alveoplasty
- ❑ Consultation for Cosmetic Surgery

Teeth to be Extracted

Patient's Right A B C D E | F G H I J *Patient's Left*

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

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 the patient require premedication? *Circle which applies:* Yes No

Antibiotic Used: _____

Any medical concerns requiring attention? _____

Radiographs

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

Referring Dentists Recommendation:

_____

_____

Referring Dentists Signature: **Date:**

_____ _____