MACARTHUR SURGICAL CENTRE ORAL + MAXILLOFACIAL SPECIALIST

Orthognathic Referral Form

Date of referral *

Day Month Year

Priority *

Please Select

Patient Information

Name *

Prefix First Name Last Name

Phone number *

Email

Patient's existing and pre-existing risk factors *

- ☐ Gum disease
- ☐ Risk of osteonecrosis
- ☐ Diabetes
- ☐ Cardiovascular disease
- ☐ Taking anticoagulant medication

- ☐ Bleeding disorders
- ☐ Reaction to anaesthetic
- ☐ Anxious patient
- ☐ Malnutrition or being underweight
- ☐ Sleep apnea
- ☐ Other

For Consultation and Care Regarding

Our procedures *

- ☐ Maxillary osteotomy
- ☐ Subapical Mandibular Impaction (SAMI)
- ☐ Mandibular osteotomy
- ☐ Rapid Maxillary Expansion (RAME)
- ☐ BiMax (bimaxillary surgery)
- ☐ Segmental jaw surgery
- ☐ Bilateral Sagittal Split Osteotomy (BSSO)
- ☐ Genioplasty
- ☐ Management of complication
- ☐ Other

Is there any tooth to be extracted prior to the jaw surgery? *

Please Select

(If Yes, please specify it on the clinical notes below)

Has the patient already started the orthodontic treatment? *

Please Select

How long have they been having the orthodontic treatment for?

Please Select

Was there a specific practitioner you are referring to? *

Please Select

Clinical notes to our specialist *

Supporting radiography record *

Please Select

Referring Doctor Information

Name *

Prefix First Name Last Name

Clinic or practice name *

Provider number *

Address *

Street Address

Suburb State

Postcode

Contact number *

Best email correspondence *

Tags

- [ ] Todo
- [ ] In Progress
- [ ] Done