

# OMS Referral Form

## PATIENT INFORMATION:

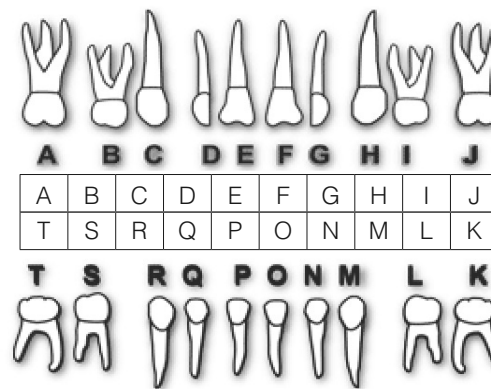
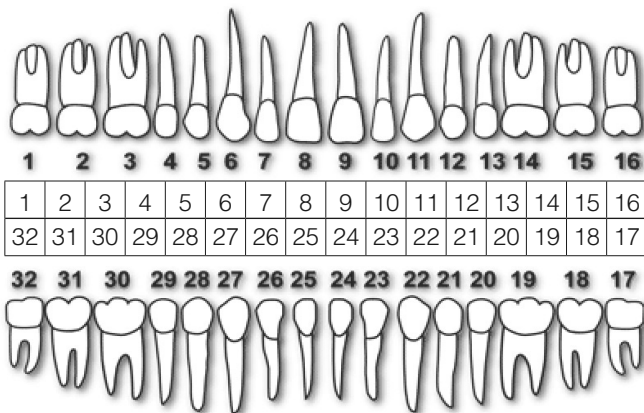
Today's Date \_\_\_\_\_  
 First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Parent / Guardian Name \_\_\_\_\_  
 Contact Telephone \_\_\_\_\_ Contact E-Mail Address \_\_\_\_\_  
 Does the patient require antibiotics prior to dental treatment?  Yes  No

## REFERRING DOCTOR'S INFORMATION:

Referred By \_\_\_\_\_ Telephone \_\_\_\_\_  
 E-Mail Address \_\_\_\_\_

## PROCEDURES:

- |   |  |                                      |
|---|--|--------------------------------------|
| <input type="checkbox"/> Extraction (see below) | <input type="checkbox"/> Exposure      | <input type="checkbox"/> Frenectomy  |
| <input type="checkbox"/> Alveoplasty            | <input type="checkbox"/> Hard Tissue   | <input type="checkbox"/> Apicoetomy  |
| <input type="checkbox"/> Biopsy                 | <input type="checkbox"/> Infection     | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Incision & Drainage    | <input type="checkbox"/> Expose & Bond |                                      |
| <input type="checkbox"/> Lesion Evaluation      | <input type="checkbox"/> Soft Tissue   |                                      |



Please Verify Teeth For Extraction \_\_\_\_\_

## CONSULTATIONS:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> TMJ                     | <input type="checkbox"/> Cleft Lip & Palate   | <input type="checkbox"/> Bone Grafting |
| <input type="checkbox"/> Implants                | <input type="checkbox"/> Cosmetic             | <input type="checkbox"/> Other _____   |
| <input type="checkbox"/> Orthognathic Evaluation | <input type="checkbox"/> Ridge Augmentation   |  |
| <input type="checkbox"/> Pre-Prosthetic          | <input type="checkbox"/> Oral / Facial Lesion |  |

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.

If X-Rays are attached, what date were they taken \_\_\_\_\_

## COMMENTS: