Department of Oral and Maxillofacial Surgery
Strong Memorial Hospital-AC4
601 Elmwood Ave, Box 705
Rochester, NY 14642 silver elevators to 4th floor

Tel: 585-275-5531
Fax: 585-461-5420

Oral and Maxillofacial Surgery Clinic Referral Form

Patient's information:

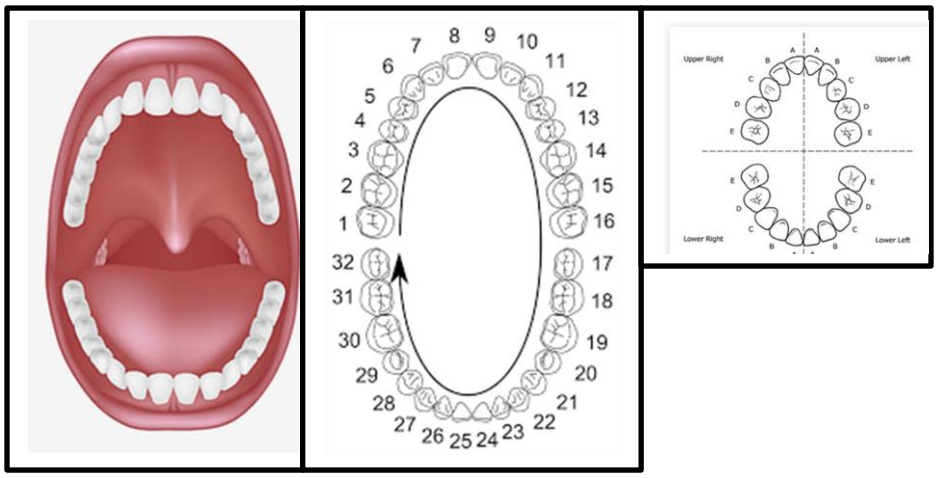
Name: _____

DOB: _____

Parent-Guardian name_____

Primary phone number: _____

Secondary phone number: _____



Reason for referral:

Extraction of teeth: _____ (please indicate on diagram)

Consultation for biopsy of lesion: _____ please indicate site(s) on diagram)

Surgical Exposure of teeth: _____ (please indicate on diagram)

Consultation for placement of Implant: _____ (please indicate site(s) on diagram)

Consultation for pre-prosthetic surgery: _____ (please indicate site(s) on diagram)

Consultation for bone grafting/augmentation: _____ (please indicate site(s) on diagram)

Consultation for soft tissue grafting/augmentation: _____ (please indicate site(s) on diagram)

Consultation for orthognathic surgery_____

Consultation for TMJ surgery_____

Consultation for other procedures (please be specific) _____

Referring Doctor's information:

PRINT Dr. Name_____ **Date**: _____

Signature_____ **Tel**: _____**Fax**:_____

Please fax completed form to 585-461-5420

Please email x-rays to omfs@urmc.rochester.edu. MUST HAVE 2 pt. Identifiers on pan.