Department of Oral and Maxillofacial Surgery
Strong Memorial Hospital-AC4
601 Elmwood Ave, Box 705
Rochester, NY
Tel: 585-275-9004
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Oral and Maxillofacial Surgery Clinic Referral Form

Patient's information:

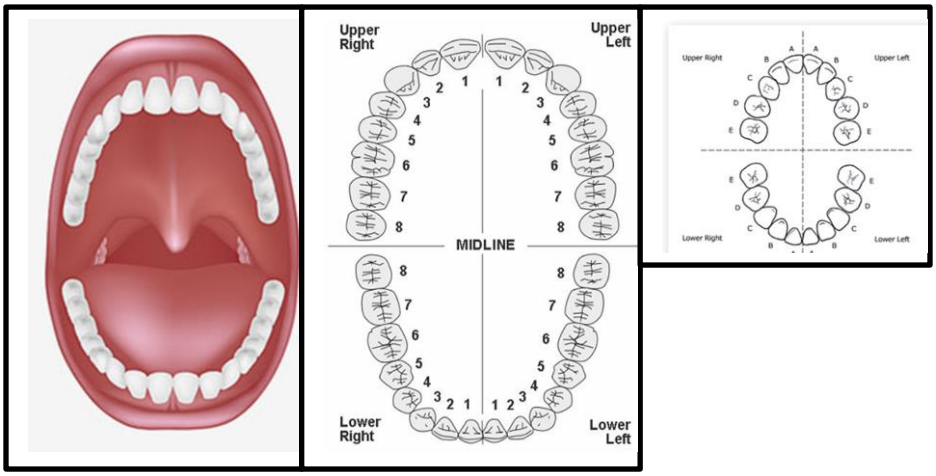
Name: _____

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:

Name_____ **Date**: _____

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

Pease fax completed form to 585-276-1883