Oral and Maxillofacial Surgery Clinic Referral Form

Oral and Maxillofacial Surgery
Strong Memorial Hospital-AC4 (silver elevators near main lobby)
601 Elmwood Ave, Box 705
Rochester, NY

http://omfs.urmc.edu Tel: 585-275-5531 **Please fax completed form to 585-276-1883**

Patient Information

Name: _____

Date of birth: _____

Parent/Guardian name: _____

Primary phone number: _____

Secondary phone number: _____

Reason for referral (please indicate on diagram)

Extraction of teeth: _____

Consultation for biopsy of lesion: _____

Surgical Exposure of teeth: _____

Consultation for placement of Implant: _____

Consultation for pre-prosthetic surgery: _____

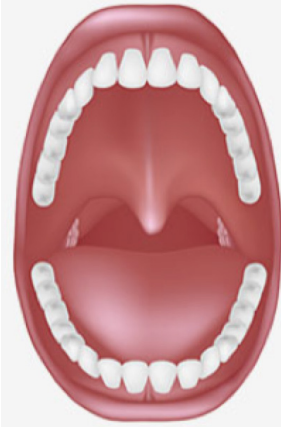
Consultation for bone grafting/augmentation: _____

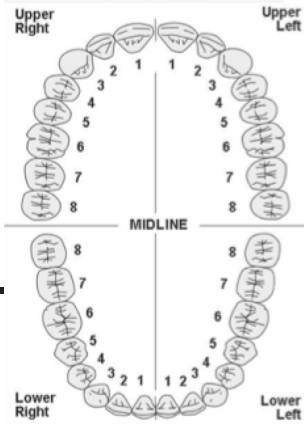
Consultation for soft tissue grafting/augmentation: _____

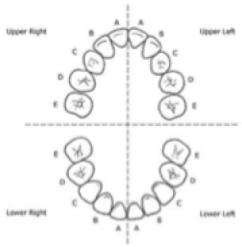
Consultation for orthognathic surgery: _____

Consultation for TMJ surgery: _____

Consultation for other
procedures (please be specific): _____







Referring Doctor's Information

Name: _____

Date: _____

Tel: _____ Fax: _____

Signature: _____