# Oral and Maxillofacial Surgery Clinic Referral Form

**Department of Oral and Maxillofacial Surgery**
**Strong Memorial Hospital-AC4**
**601 Elmwood Ave, Box 705**
**Rochester, NY 14642**

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

## Patient Information

Name: _____

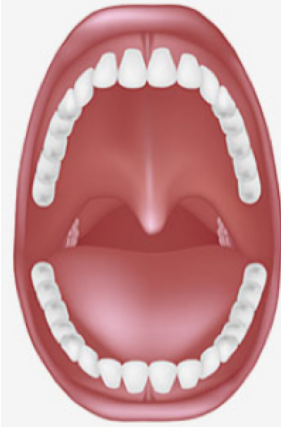
Date of birth: _____

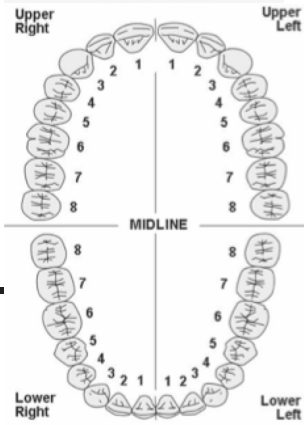
Parent/Guardian name: _____

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: _____