Oral & Maxillofacial Clinic Referral Form

Department of Oral & Maxillofacial Surgery
Strong Memorial Hospital –AC4
Silver Elevators, 4th Floor

First appointment is a Consultation, which must be scheduled by the patient.

Please Email X-rays & Referral to omfs@urmc.rochester.edu
****Include patient name and date of birth in the subject line****
Please fill out all patient demographic and referring provider information.

601 Elmwood Ave., Box 705
Rochester, NY 14642
Tel: 585-275-5531 Option #3
Fax: 585-461-5420

Patient's information: Fill out completely

Name: _____

DOB: _____

Parent-Guardian name: _____

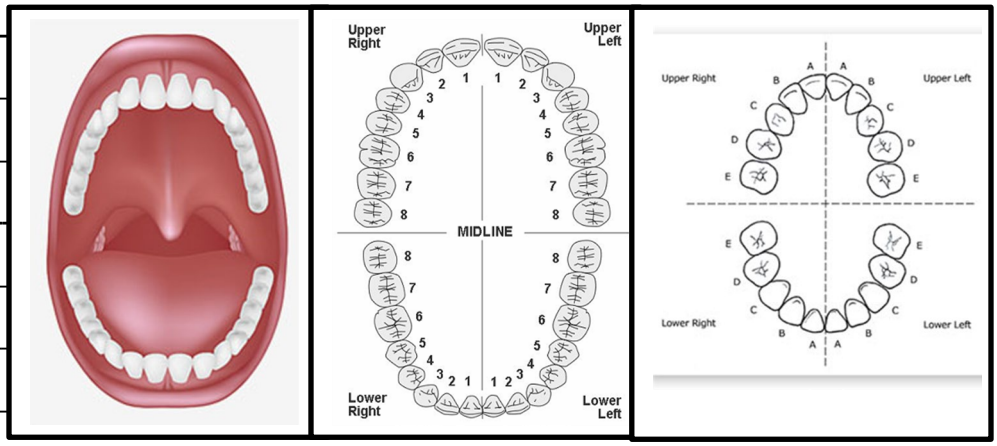
Primary phone number: _____

Secondary phone number: _____

Insurance name: _____

Insurance ID number: _____

Date of Last Panoramic x-ray: _____



MUST HAVE PATIENT IDENTIFIERS ON PAN:

Reason for referral:

Extraction of teeth: _____(please indicate site(s) on diagram)

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

Surgical Exposure of teeth: _____(please indicate site(s) 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: Fill out completely!

Name: _____ **Date**: _____ **Facility Name**: _____

Signature: _____ **Tel**: _____ **Fax**: _____

Please email to omfs@urmc.rochester.edu

- **Please write legibly and complete the referral to expedite scheduling. Thank you!**