

## **FAX REFERRAL TO 415-749-3305**

SCHOOL OF DC																
ORAL & MAXILLOFA	ACIAL SUR	GERY R	EFERRA	L FORM	<b>1 –</b> P	lease co	omple	te the	follow	ing inf	ormati	ion				
REFERRAL INFORM	ATION															
Select Doctor:	☐ Stud	☐ Student ☐ Faculty														
Date:	ctor:															
MM/DI	-															
Referring Doctor Ac																
	FAX#:															
DATIENT INCORNA	TION															
PATIENT INFORMA	TION								Da	to of I	Oirth. /	N 4 N 4 / D	D (\(\sum_{\sym_{\s\sym_{\sym_{\sym_{\sym_{\sym_{\sym_\}\cun_\sym_\}\cun_\sym_\sym_\sym_\sym_\sym_\sym_\sym_\sym			
Patient's Name:	Date of Birth: (MM/DD/YYYY):															
Please check prefer	red telepl	none co	ntact:													
☐ Home:	-			Work:					☐ Ce	ell:						
INFORMATION MU	ST BE COI	MPLETE	D IN FU	LL – PRI	NT C	CLEARLY	′									
Urgency of care: ☐ Emergent ☐ Urgent ☐ Routine																
<b>RADIOGRAPHS:</b> □ Please take X-rays □ X-ray							ys with Patient    X-rays mailed									
Digital radiogra	phs ( <i>FAX I</i>	IOT acc	epted):		e-ma	ail (sfor	alsurg	gery@p	oacific.	edu)						
Reason for Refe	rral:															
☐ Extraction:	10	12	1123	121	_	1 =	1120	V-1	18915	W11						
1 2	3 4		C 6	D 7	E 8	F 9	G 10				14	15	16			
32 31	30 29	28	27	26	25	24	23	22	21	20	19	18	17			
☐ Jeanlants Crasti	T	170	R	Q	Р	0	N									
☐ Orthognathic Su																
☐ Trauma ☐	Bone Graf	ting	ППП	MJ I		Other:			Date of Birth: (MM/DD/YYYY):    Cell:   Routine							
☐ Discuss Anesthe	etic Optior	ns (Local	, Sedati													
Relevant Medical H	listory:															
Current Medications/ Allergies:																
Is Patient capable of	□Yes	☐ Yes [														
Does Patient require English translation services?							☐ Yes, Language									

**Additional Comments/Details:**