KEYSTONE
ORAL SURGERY & IMPLANT CENTER

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ORAL SURGERY REFERRAL FORM

Patient Name: ____ Phone No: _________________

Referring Doctor Name: ______________________________________ Phone No: _________________

Address: ____

Reason for Referral:

- Surgical Removal of Erupted Tooth
- Soft Tissue Impaction Tooth #
- Partial Bony Impaction Tooth #
- Full Bony Impaction Tooth #
- Surgical Removal of Root Tip
- Removal of Tori ☐UR☐ UL☐ LR☐ LL
- Bone Graft
- Implants
- Biopsy
- Frenectomy
- Alveoplasty
- Consultation for Cosmetic Surgery

Teeth to be Extracted

PATIENT'S RIGHT		PATIENT'S LEFT
	1 2 3 4 5 6 7 8	9 10 11 12 13 14 15 16
	A B C D E	F G H I J
	T S R Q P	O N M L K
	32 31 30 29 28 27 26 25	24 23 22 21 20 19 18 17

Does Patient Require Premedication Yes ☐ No ☐
Antibiotics Used: ____
Any Medical Concerns Requires Attention: ____

Radiographs

- Please take/send copy
- Patient will bring copy
- I will send / Please return

Referring Dentist's Recommendation:

____

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Referring Doctor Signature: ____________________ **Date:**________________

This referral form is also available at https://www.keystoneomfs.com/dr_referral