# Oral and Maxillofacial Surgery Referral Form

**University of Illinois at Chicago College of Dentistry**
**Oral Surgery Fax: (312)-996-5987, email: oralsurgery@uic.edu**

**Date of referral:** _____

**Referred by:** _____ **Office phone/email/fax:** _____

**Patient name/parent (for minors):** _____ **DOB:** _____

**Patient phone:** _____ **Alternative phone:** _____

**Patient email:** _____

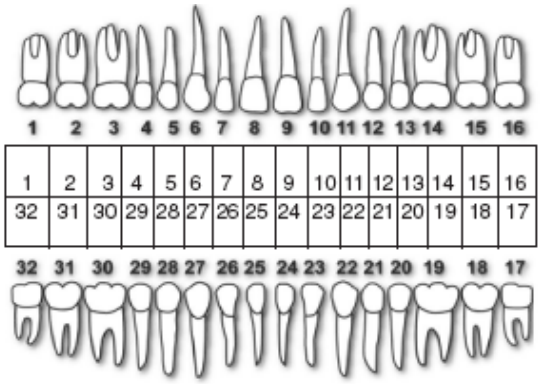
**Patient INSURANCE ID # AND NAME:** _____

_____

**Dentoalveolar surgery:**

- ❑ **Extraction teeth #s:** _____

  **Please mark teeth to be extracted on diagram**




- ❑ **Alveoplasty:** _____
- ❑ **Incision and drainage:** _____
- ❑ **Apicoectomy:** _____
- ❑ **Biopsy:** _____
- ❑ **Expose and bond:** _____
- ❑ **Frenectomy:** _____
- ❑ **Dentoalveolar trauma:** _____

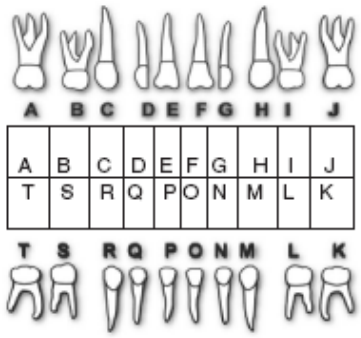
**Dental implants #:** _____

**Pathology/Biopsy:** _____

**Orthognathic evaluation:** _____

**TMJ evaluation:** _____

**Cosmetic facial surgery:** _____




**Radiographs:**

- ❑ **Attached to this referral**
- ❑ **Will send by email (oralsurgery@uic.edu)**
- ❑ **Will send by US mail**
- ❑ **None available**

**Medical History:**

- ❑ **Negative**
- ❑ **Significant:** _____
- ❑ **Special needs:** _____

**Anesthesia Recommendations:**

- ❑ **Local anesthesia**
- ❑ **IV sedation**
- ❑ **General anesthesia, operating room**

**Indicate facial injury, swelling, or other findings**

**Other/Comments:** _____

_____

**Person completing this form:** _____ **Signature (initials):** _____

**Phone:** _____ **Fax:** _____ **email:** _____

**INCOMPLETE REFERRALS WILL BE VOIDED.**

**PLEASE INFORM PATIENT THAT THE FIRST APPOINTMENT WITH US IS ONLY A CONSULTATION.**