School of Dental Medicine
UNIVERSITY OF COLORADO **ANSCHUTZ MEDICAL CAMPUS**

Oral and Maxillofacial Surgery Referral Form

Please email this form and all relevant radiographs to sdm-omfsdfp@ucdenver.edu or fax to 303-724-0672. Please call 303-724-4672 with any questions or urgent referrals
First appointment will be an evaluation only**.**

This Referral Is ☐ Emergent (Send Patient to Emergency Department) ☐ Urgent (24-72 Hours) ☐ Routine (Next Available)

Patient Information

Name: _____ DOB: _____

Gender Identity: ☐ Male ☐ Female ☐ Transgender ☐ Other Language: _____ Interpreter Needed: ☐ Y ☐ N

Address: _____

Contact Number: _____ Parent/Guardian/Caretaker Name: _____

Dental Insurance: _____

Medical Insurance: _____

☐ X-rays mailed/emailed, date taken: _____ ☐ Need X-rays

Reason for Referral

☐ Extractions
☐ Implants: Surgical Only
☐ Trauma
☐ Biopsy/Pathology
☐ IV Sedation Needs
☐ General Anesthesia
☐ Expose and Bond
☐ Sleep Apnea
☐ Orthognathic
☐ Other (please specify below)

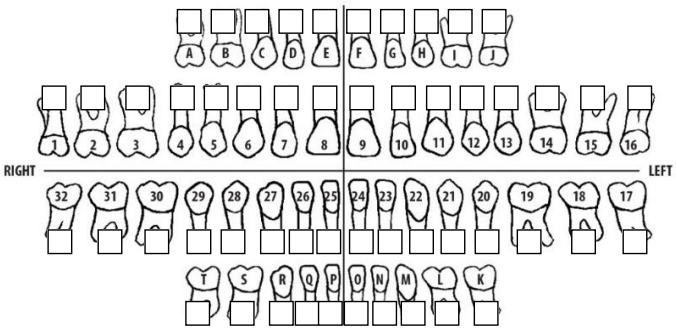
☐ Complex Medical Needs: _____

☐ Other/Detailed instructions: _____

_____

_____

Please mark below the tooth/teeth of referral:



Referral From

Dentist/Provider: _____ Clinic/Practice: _____

Address: _____

Phone: _____ Fax/Email: _____

Signature of Referring Dentist: _____ Date: _____