



Oral and Maxillofacial Surgery Referral Form

Please email this form and all relevant radiographs to sdmreferral@cuanschutz.edu or fax to 303-724-0600. 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: Male Female 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

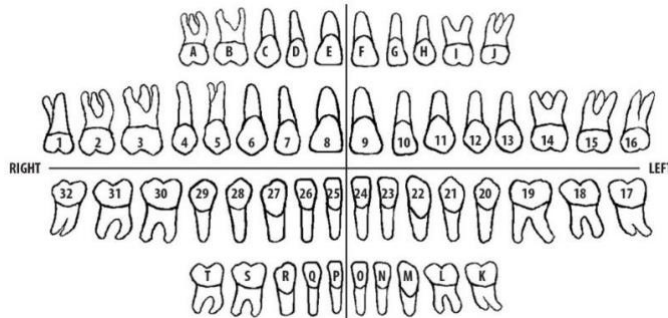
Reason for Referral

- | | | |
|--|---|---|
| <input type="checkbox"/> Extractions | <input type="checkbox"/> IV Sedation Needs | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Implants: Surgical Only | <input type="checkbox"/> General Anesthesia | <input type="checkbox"/> Orthognathic |
| <input type="checkbox"/> Trauma | <input type="checkbox"/> Expose and Bond | <input type="checkbox"/> Other (please specify below) |
| <input type="checkbox"/> Biopsy/Pathology | | |

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: _____