University of Colorado **Anschutz**

School of Dental Medicine

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)

Provider (optional): ☐ Dr. Eric Reimer, DDS ☐ Dr. Brian Poore, DDS ☐ Dr. William McMunn III, DDS, MD, FACS

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

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

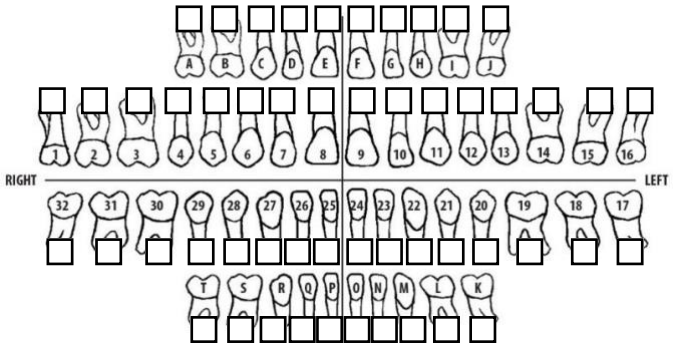
Complex Medical Needs: _____

Other/Detailed instructions: _____

_____

_____

Please mark below the tooth/teeth of referral:



Referral From

Provider: _____ Clinic/Practice: _____

Address: _____

Phone: _____ Fax/Email: _____

Signature of Referring Provider: _____ Date: _____