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): _______________________________________________________

Patient 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

Other/Comments: _______________________________________________________________________

_____________________________________________________________________________________

Person completing this form: ___________________________ Signature (initials): ______

Phone: ___________________ Fax: ___________________ email: ___________________

INCOMPLETE REFERRALS WILL BE VOIDED.