

FACE2FACE

MAXILLOFACIAL SURGERY CENTRE

PATIENT REFERRAL FORM

PATIENT NAME: _____

REFERRING DOCTOR: _____

REASON FOR REFERRAL:

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15
A B C D E F G H I J

T S R Q P O N M L K
32 31 29 28 27 26 25 24 23 22 21 20 19 18 17

___ Consultation

___ IV Sedation/Anesthesia

___ Extraction

___ Botox/Facial Fillers/Kybella

___ Wisdom Teeth

___ Pre-Prosthetic Surgery

___ Bone Grafting

___ TMJ Problems

___ Biopsy

___ Dental Implants

___ Exposure and Bonding

___ X-rays given to patient

PATIENT INSTRUCTIONS

- 1) If sedation is requested please bring a responsible adult with you to drive you home. No food or liquid including water by mouth 8 hours prior to your appointment
- 2) Please bring referral slip at time of appointment and any available x-rays
- 3) Please bring all medical and dental insurance information with you
- 4) Bring a list of all medications taken daily
- 5) 48 hours notice is required for all appointment cancellations