



Aesthetic Surgical Arts

Oral and Maxillofacial Surgery

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ORAL & MAXILLOFACIAL REFERRAL SHEET

Patient Name: _____ Phone: _____

Referring Physician: _____ Phone: _____

*****Please remove the teeth circled below*****

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
a b c d e f g h i j

l s r q p o n m i k
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

____ Expose and bond: _____

____ Orthognathic Surgery (Jaw and Facial Deformities)

____ Implant Evaluation

____ Cleft Lip and Palate

____ Head and Neck Reconstruction

____ Biopsy Location: _____

Comments: _____

Signature _____