Oral and Maxillofacial Surgery

REFERRAL REQUEST FOR:

NAME ________________________________

APPOINTMENT ________________________________

Please indicate the doctor that your patient would prefer to see:

☐ First Available
☐ John B. Ballard, D.M.D., P.H.D.
☐ Patrick J. Louis, D.D.S., M.D.
☐ Jason R. Miller, D.M.D., M.D.
☐ Victor F. Szymela, D.M.D., M.D.
☐ Peter D. Waite, M.P.H., D.D.S., M.D.

Please evaluate for treatment:

☐ I am sending radiographs which may be helpful
☐ Please return radiographs
☐ Please send report of consult and/or treatment
☐ Please call me about this patient
☐ Please contact this patient for an appointment
☐ PATIENT’S phone # ________________________________

Signature __________________________________________ Date ________________

WHITE - PATIENT CANARY - REFERRING DOCTOR CARD - MAIL TO OMS TKC
kckos875 Rev 8/05