

30 Baldwin Blvd, Suite:95 Shamokin Dam PA 17876 Email: contact@keystoneomfs.com Phone: 570 884 8321 Fax: 570 256 1772

Dr. Assabi Isaac, DDS Dr. Pranathi Reddy, DDS

Diplomats, American Board of Oral and Maxillofacial Surgery

website: www.keystoneomfs.com

ORAL SURGERY REFERRAL FORM

Reason for Referral: Surgical Removal of Erupted Tooth Soft Tissue Impaction Tooth # Partial Bony Impaction Tooth # Surgical Removal of Root Tip Surgical Removal of Root Tip Removal of Tori UR UL LR LL T S R Q P Surgical Removal of Root Tip Coes Patient Require Premedication T S R Q P Surgical Removal of Root Tip T S R Q P Surgical Removal of Tori UR T S R Q P Surgical Removal of Tori UR T S R Q P Surgical Removal of Tori UR T S R Q P Surgical Removal of Tori UR T S R Q P Surgical Removal of Tori UR T S R Q P Surgical Removal of Root Tip Surgical Removal of	Patient Name:	Phone No:
Surgical Removal of Erupted Tooth Soft Tissue Impaction Tooth # Partial Bony Impaction Tooth # Surgical Removal of Root Tip Surgical Removal of Root Tip Removal of Tori UR UL LR LL 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 PATIENT'S RIGHT T S R Q P Surgical Removal of Root Tip T S R Q P Surgical Removal of Root Tip T S R Q P Surgical Removal of Root Tip Surgical Removal of Root Tip A B C D E F G H I J PATIENT'S RIGHT T S R Q P Surgical Removal of Root Tip Surgical Removal of Root Tip A B C D E F G H I J PATIENT'S LEFT Does Patient Require Premedication Antibiotics Used: Surgical Require Premedication Yes No Surgical Removal of Erupted Tooth # Surgical Removal of Eventual Surgical Regular Surgical Regu	Referring Doctor Name:	Phone No:
Surgical Removal of Erupted Tooth Soft Tissue Impaction Tooth # Partial Bony Impaction Tooth # Surgical Removal of Root Tip Removal of Tori UR UL LR LL 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 PATIENT'S A B C D E F G H I J PATIENT'S RIGHT T S R Q P O N M L K 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 POSS Patient Require Premedication Antibiotics Used: Any Medical Concerns Requires Attention: Radiographs Please take/send copy Patient will bring copy I will send / Please return Peferring Dentist's Recommendation:	Address:	
Soft Tissue Impaction Tooth # Partial Bony Impaction Tooth # Surgical Removal of Root Tip Removal of Tori UR UL LR LL 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 PATIENT'S A B C D E F G H I J PATIENT'S RIGHT T S R Q P O N M L K 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 Poes Patient Require Premedication Antibiotics Used: Any Medical Concerns Requires Attention: Radiographs Please take/send copy Patient will bring copy I will send / Please return Preferring Dentist's Recommendation:	Reason for Referral:	
PATIENT'S RIGHT T S R Q P O N M L K 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 Does Patient Require Premedication Antibiotics Used: Any Medical Concerns Requires Attention: Radiographs O Please take/send copy Patient will bring copy I will send / Please return Peferring Dentist's Recommendation:	 Soft Tissue Impaction Tooth # Partial Bony Impaction Tooth # Full Bony Impaction Tooth # Surgical Removal of Root Tip 	ImplantsBiopsyFrenectomyAlveoplasty
PATIENT'S RIGHT T S R Q P O N M L K 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 Does Patient Require Premedication Antibiotics Used: Any Medical Concerns Requires Attention: Radiographs O Please take/send copy Patient will bring copy I will send / Please return Peferring Dentist's Recommendation:	1 2 3 4 5 6 7 8	9 10 11 12 13 14 15 16
Does Patient Require Premedication Antibiotics Used: Any Medical Concerns Requires Attention: Radiographs Please take/send copy Patient will bring copy I will send / Please return Peferring Dentist's Recommendation:	RIGHT	F G H I J PATIENT'S
Antibiotics Used: Any Medical Concerns Requires Attention: Radiographs Please take/send copy Patient will bring copy I will send / Please return eferring Dentist's Recommendation:	32 31 30 29 28 27 26 25	24 23 22 21 20 19 18 17
 Please take/send copy Patient will bring copy I will send / Please return eferring Dentist's Recommendation:	Antibiotics Used:	
	Please take/send copyPatient will bring copy	
Poforring Doctor Signature:	Referring Dentist's Recommendation:	
Poforring Doctor Signature:		
	Referring Doctor Signature:	Date: