The Ohio State University

COLLEGE OF DENTISTRY

ORAL AND MAXILLOFACIAL SURGERY
REFERRAL REQUEST

Preferred Surgeon

☐ any available

☐ Dr. Hany Emam

☐ Dr. Courtney Jatana

☐ Dr. Kelly Kennedy

☐ Dr. Peter Larsen

☐ Dr. Greg Ness

Referred By

Name: ______________________

Facility: ______________________

Phone: ______________________

Patient Information

Name: ______________________

Birth date: ______________ Gender: ☐ M ☐ F

Address: ______________________

____

Phone: ______________________

Dental Ins.: ______________________

Medical Ins.: ______________________

ID#: ______________________

Current x-rays (<12 months) required OR we will take new films at patient’s expense

☐ MAILED ON ______________________ ☐ PATIENT TO BRING TO CONSULTANT

Reason for Referral

☐ third molars

☐ orthognathic surgery

☐ alveoloplasty

☐ implants/bone grafts

☐ pathology

☐ extractions

☐ TMJ

☐ other (specify below)

Specific concerns: ______________________

Indicate teeth to be extracted with an X. Indicate recommended implant sites with a circle.

		A		B		C		D		E		F		G		H		I		J

		A	B	C	D	E	F	G	H	I	J				
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
		T	S	R	Q	P	O	N	M	L	K				

Significant Medical History (required): ______________________

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Signature of Referring Provider: ______________________ Date: __________

NOTE: Referrals are accepted on a case by case basis. We do not contact new patients to schedule appointments; patient should call to schedule. Thank you for your referral.

Postle Hall, 2nd Floor | 305 West 12th Avenue | Columbus, Ohio 43210 | Phone: 614-292-5144 | Fax: 614-292-1103