Lincoln Park Oral and Cosmetic Surgery
Specialist Referral Form

Patient Name: _____ Phone No: _____
Referring Doctor Name: _____ Phone No: _____
Address: _____
Provider email: _____

Reason for Referral:

- ☐ Surgical Removal of Erupted Tooth
- ☐ Soft Tissue Impaction Tooth # _____
- ☐ Partial Bony Impaction Tooth # _____
- ☐ Full Bony Impaction Tooth # _____
- ☐ Surgical Removal of Root Tip _____
- ☐ Bone Graft
- ☐ Implants
- ☐ Removal of Tori ☐ UR ☐ UL ☐ LR ☐ LL
- ☐ Biopsy
- ☐ Frenectomy
- ☐ Alveoplasty
- ☐ Consultation for Cosmetic Surgery

Teeth to be Extracted

				A	B	C	D	E	F	G	H	I	J			
Patient's Right	**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			

Patient's Left

Does patient require premedication? ◯ Yes ◯ No
Antibiotic used _____
Any medical concerns requiring attention _____

Radiographs

- ☐ Please take/send copy
- ☐ Patient will bring copy
- ☐ I will send / Please return

Referring Dentist's Recommendation:

_____
_____
_____

Referring Dentist's signature: _____ Date: _____

Submit