Dr. Kenneth M. Klamut, DDS

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Oral and Maxillofacial Surgery Referral
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Patient's Name: ______________________ Date: ____________

Patient's Date of Birth: ______________________

Patient's Phone Number: ______________________

Referred by: ______________________

Treatment: ______________________

Comments: ______________________

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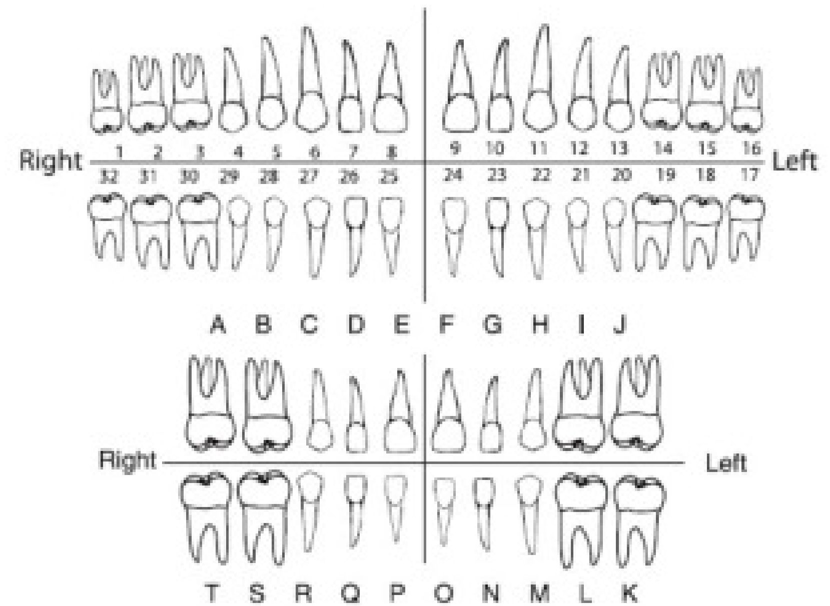

☐ Please call me before appointment
☐ Please call me after consultation and prior to surgery
☐ Post-operative report is sufficient
☐ Please call me after surgery for a surgical report

TREATMENT:

☐ CONSULTATION
☐ EXTRACTION (please indicate tooth number above)
☐ INTRAVENEOUS OR GENERAL ANESTHESIA
☐ ALVELOPLASTY
☐ BIOPSY
☐ INCISION AND DRAINAGE
☐ ROOT CANAL THERAPY
☐ APICOECTOMY AND RETROGRADE FILLING
☐ IMPANT SURGERY
☐ EXPOSURE OF UNERUPTED TOOTH
☐ TMJ EVALUATION / FACIAL PAIN EVALUATION
☐ CROWN LENTHENING

☐ FRENECTOMY
☐ GUIDED TISSUE REGENERATION
☐ REMOVAL OF TORUS
☐ FREE GINGIVAL GRAFT
☐ TUBEROSITY REDUCTION
☐ ENUCLEATION OF CYST
☐ EXCISION OF TUMOR
☐ FACIAL FRACTURE
☐ PERIODONTAL SURGERY
☐ REMOVAL OF HYPERTROPHIED TISSUE
☐ BONE GRAFTING (INFUSE®)

RADIOGRAPHS / CLINICAL PHOTOS

☐ BEING MAILED
☐ GIVEN TO PATIENT
☐ EMAILED TO OFFICE
☐ PLEASE TAKE
☐ NO X-RAY