NORTH COAST

MAXILLOFACIAL SURGERY

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Patient Details

First Name ______________________________ Last Name ______________________________
DOB _____ / _____ / _____ Phone ________________ Email ______________________________
Address ____
Suburb ________________________________ State _______________ Postcode _______________

Referral Details ☐ Urgent ☐ Routine

Surgical Extraction

☐ Wisdom teeth (specify) ______________________
☐ Other (Specify) ____________________________

Orthodontic

☐ Impacted Canine management
☐ TAD placement
☐ Orthognathic surgery / malocclusion

Pathology

☐ Muscosal/Soft tissue lesion
☐ Intra-bony lesion
☐ Removal of skin lesion
☐ TMJ / facial pain

Implants

☐ Implant/s placement (specify) ________________
☐ Bone graft / sinus lift

Facial Aesthetic Surgery

☐ Rhinoplasty
☐ Scar revision
☐ Other (specify) ____________________________

Facial Trauma

☐ Bony trauma – acute
☐ Bony trauma – delayed
☐ Soft tissue trauma

Other

☐ Pre-prosthetic surgery
☐ Other (specify) ____________________________

Clinical Details

____
____
____
____

Medical History

Medications

☐ Anticoagulants ____________________________
☐ Antiresorptives ___________________________
Other medications ___________________________
____
Allergies ____________________________________
Medical conditions *(attach GP health summary if available)*
____
____
____

Investigations / Imaging Completed

☐ PA
☐ OPG
☐ Lat ceph
☐ CT/CBCT

Other investigations ordered

____
____
Radiology/Pathology Provider __________________
(Please attach or email imaging if completed in your practice)

Referring Doctor / Dentist

Name ______________________________ Provider No ______________________________
Practice ____
Location ____
Phone ____________________________ Email ______________________________
Date of Referral __________ / __________ / __________ Signature ______________________

Please click here to send direct via email - referrals@northcoastmaxfacs.com.au