REFERRAL FORM

Brentwood OMFS
Oral & Maxillofacial Surgery

Dr. Ian Matthew
Dr. Ray Grewal
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& Associates

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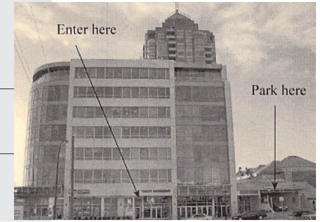
Burnaby, BC V5C 6R6

Phone (604) 294-8889
Fax (604) 294-8874
Email brentwoodoms@gmail.com
Website www.brentwoodoralsurgery.ca

Please bring this referral to your appointment on:

DATE

TIME



If by necessity you must cancel your appointment for surgery, please notify us at least two days in advance.

Patient

Birth Date

Guardian (if applicable)

Patient Phone

Patient Address

CITY

POSTAL CODE

Referred by

Date referred

Referral Phone

○ Please take Radiograph
○ Radiograph enclosed
○ Radiograph given to patient

Dental Insurance Information

Plan Name: ____________________
Policy No: ____________________
ID No: ____________________
Dependent No: ____________________
Insured Name: ____________________
Insured DOB: ____________________
Basic Percentage: ____________________
Annual Maximum: ____________________

Reason for Referral

○ 3rd Molar
○ Extractions
○ Implants
○ Augmentation
  ○ Sinus Lift
  ○ Socket Graft
  ○ Ridge
○ Botox
○ Jaw Fracture / Trauma
○ Alveoplasty
○ Apicoectomy
○ Expose & Bond
○ Frenectomy
○ Infection
○ Lesion
○ TMJ
○ Orthognathic
○ Other ____________

Please indicate teeth to be removed or surgery to be performed

18 17 16 15 14 13 12 11	21 22 23 24 25 26 27 28	
48 47 46 45 44 43 42 41	31 32 33 34 35 36 37 38	
R 55 54 53 52 51	61 62 63 64 65	L
85 84 83 82 81	71 72 73 74 75	

Comments