

Oral Surgery Referral Letter

To: Mr.M. Sharif Nayyar, Oral Surgeon
BDS, FDSRCSEd, M Surg Dent RCSEd, FFDRCSI (Oral Surgery)

Dated: _____

Patient Name: _____ Date of Birth: _____

Address: _____

Tel: Home: _____ Work: _____ Mobile: _____

An appointment for consultation and treatment regarding:

Surgical Extraction of	___	Exposure of	___
Cyst/Pathology	___	TMJ Dysfunction	___
Implant	___	Bone graft / Sinus Lift	___
Apicectomy	___	Other	___

Reason for referral/Presenting Complaint: _____

Medical history if known: _____

Referral Priority:

Urgent ___
Routine ___

Radiograph included:

Yes ___
No ___

Treatment recommended under:

LA ___
Sedation ___
GA ___

Name of Doctor:

Address: _____

Phone No: _____ Fax No: _____