Updated 12/2021

SIU Dental Associates

ORAL AND MAXILLOFACIAL SURGERY
REFERRAL REQUEST

Patient Information

Name: _____

Birth date: _____ Gender: ☐ M ☐ F

Address: _____

_____

Phone: _____

Dental Ins: _____

Medical Ins: _____

ID #: _____

Preferred Surgeon

☐ first available
☐ Dr. Ioannis Gkikas

Referred by:

Name: _____

Facility: _____

Phone: _____

Radiographs:

___Enclosed ___Patient will bring ___None provided ___Will be sent ___On AxiUm

To transfer patient records and radiographs electronically, please visit the following URL: https://sdm.siue.edu/xraydropboxfp/uploadxrays.php. Please include your office name/phone number, patient name/date of birth, and date of radiographs.

Reason for Referral

☐ Alveoloplasty
☐ Extractions
☐ Implants/bone grafts
☐ Orthognathic surgery
☐ Pathology
☐ Third molars
☐ TMJ
☐ Other (specify below)

Specific concerns: _____

Indicate teeth to be extracted with an X. Indicate recommended implant sites with a circle.

			A	B	C	D	E	F	G	H	I	J			
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			

Significant Medical History (required): _____

_____

Signature of Referring Provider: _____ Date: _____

NOTE: Referrals are accepted on a case by case basis. Appointment; Thank you for your referral.

195 University Park Drive | Edwardsville, Illinois 62025 | Phone: 618 650 5781 | Fax: 618 650 5790