



**PATIENT REFERRAL**

Date .....

Patient name .....

Address .....

Telephone ..... D.O.B. ....

- For  Pathology (including head and neck)  
 Corrective jaw surgery  
 TMD/facial pain  
 Oral/facial trauma

- Extraction of the following  
 Place dental implant/s  
 Exposure of the following



Comments .....

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Radiographs  Electronically sent  With patient  Please arrange

Referred by:

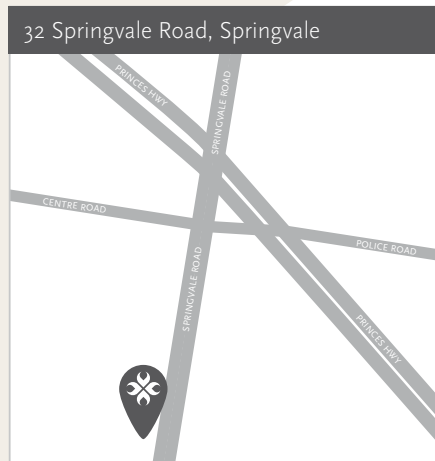
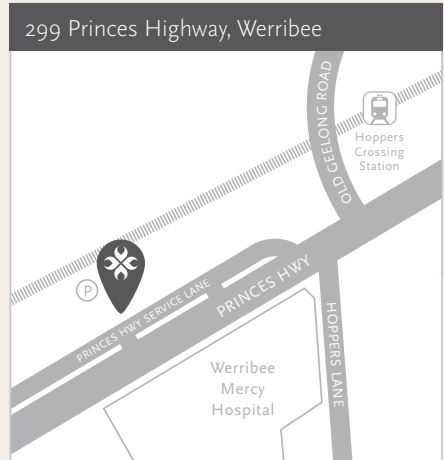
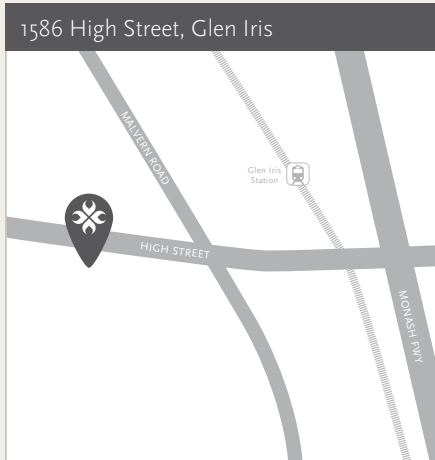
Name .....

Address .....

Phone ..... Provider No .....

## PRACTICE LOCATIONS

Off street parking available on all site



### CONTACT DETAILS & BUSINESS HOURS

8.30am to 5pm Monday to Friday  
(Please note we are closed all major public holidays)

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F: (03) 9731 1999

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