

Referral Slip To
RONALD A. THOMPSON JR., D.D.S
 Diplomate, American Board of Oral and Maxillofacial Surgery

www.thompsonoralsurgery.com

Westbrook Centre
 2705 S. Berkley Road, Suite 4D
 Kokomo, Indiana 46902
 Telephone (765) 453-5444 Fax: (765) 453-5480

Patient's Name: _____

Date of Referral: _____ Appointment Date: _____ Time: _____

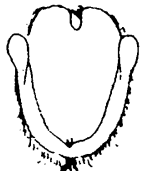
Referred by: _____ Patient Phone: _____

Radiographs: Being Mailed
 Given to Patient
 Being Emailed
 Please Take

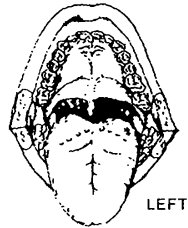
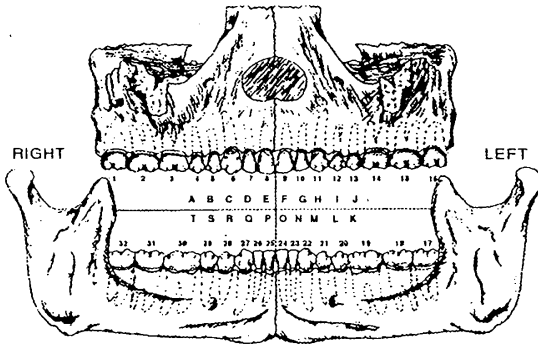
PATIENTS DESIRING IV SEDATION ANESTHESIA
 WILL NEED TO SCHEDULE A CONSULTATION APPOINTMENT
 WITH DR. THOMPSON PRIOR TO SCHEDULING SURGERY.
 THE CONSULTATION WILL INCLUDE A DISCUSSION OF THE
 PROCEDURE, ANESTHESIA, AND PATIENT'S MEDICAL HISTORY.



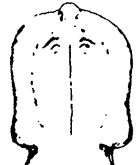
RIGHT



EDENTULOUS



LEFT



EDENTULOUS

PLEASE INDICATE AREA OR TEETH TO BE EVALUATED FOR TREATMENT

- | | |
|--|---|
| <input type="checkbox"/> Extraction
<input type="checkbox"/> Third Molar Extraction
<input type="checkbox"/> Orthodontic Exposure
<input type="checkbox"/> Implant
<input type="checkbox"/> Pathology
<input type="checkbox"/> Alveoplasty
<input type="checkbox"/> Extraction with immediate implant placement, if possible
<input type="checkbox"/> Extraction with bone replacement for future implant (Extraction Site Augmentation)
<input type="checkbox"/> iCAT 3-D CBCT for guided implant surgery | Special Remarks:

_____ |
|--|---|

