V I C T O R I A N
ORAL & FACIAL SURGEONS

☐ **Dr. Sam Vecro**
☐ **Dr. Brent Woods**

REFERRAL FOR SURGICAL OPINION / MANAGEMENT

Dear Dr Sam Verco / Dr Brent Woods
Next available surgeon

Date : _____

I wish to refer to you _____

Date of Birth _____ Telephone _____

Patient's Relevant Medical History _____

_____

For consultation and treatment regarding

☐ Surgical Removal of indicated teeth or roots
☐ Implants to replace Tooth / Teeth
☐ Facial Injury
☐ Orthognathic (Corrective Jaw) Surgery
☐ Pathological Lesions in the Mouth / Jaw(s)
☐ Temporomandibular Joint Condition

Please specify

_____

_____

ALL APPOINTMENTS PLEASE CALL **03 9592 6445**

Referral by Dr. _____ Provider Number _____

Address _____

Signature _____

RADIOGRAPHS ☐ Enclosed ☐ Emailed ☐ To be obtained

Referral valid for ☐ 12 months ☐ Indefinite

Appointment Location ☐ 759 Nepean Hwy, Brighton East, VIC 3187