



RANDALL M. WILK, DDS, PhD, MD

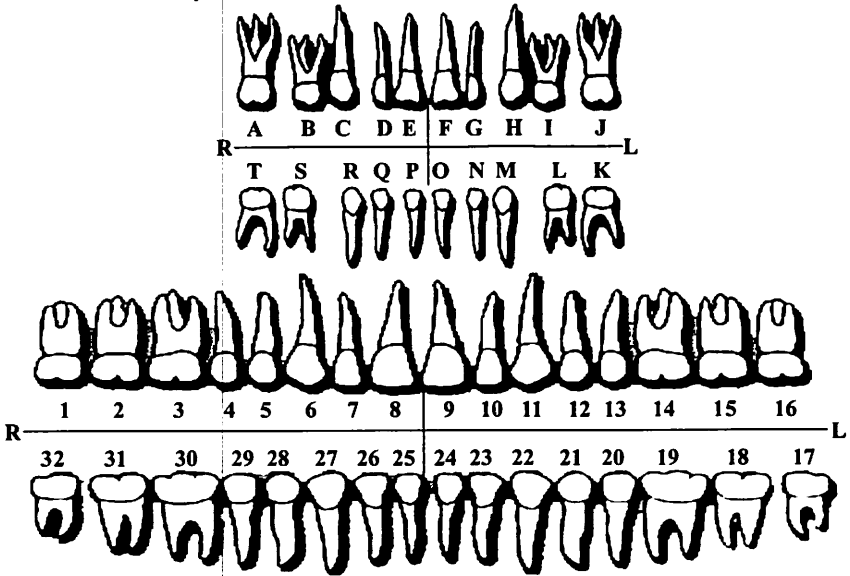
DIPLOMATES AMERICAN BOARD OF ORAL & MAXILLOFACIAL SURGERY
FELLOWS AMERICAN ASSOCIATION OF ORAL & MAXILLOFACIAL SURGEONS
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REFERRAL SLIP

Date _____ 20__

Patient: _____ Patient phone # _____

Please indicate necessary treatment:



Specific Concerns / Comments: _____

Referral #: _____

If preoperative radiographs are available please forward before appointment or have patient bring them.

On the day of the surgery appointment a responsible adult **MUST** accompany the patient to the office for transportation home.

No food or drink should be taken by mouth for 6 hours prior to the surgical appointment unless otherwise instructed.

Minors must be accompanied by parents or legal guardian.

Print Physician Name _____ Signed _____ Referring Doctor _____

Office Phone # _____