



Referral Request

Division of Oral and Maxillofacial Surgery (OMS)

Phone 507-266-0585 Fax 507-538-7473
eFax rstomsappt@mayo.edu

(complete fields or place patient label here)

Patient Name (First Middle Last)	
Birth Date (mm-dd-yyyy)	Room Number (if applicable)
Mayo Clinic Number	

**TO BE
SCANNED**

Form content retained in medical record.
Route to HIMS Scanning.

<input type="checkbox"/> First available with any surgeon	<input type="checkbox"/> K. Arce	<input type="checkbox"/> K.S. Ettinger	<input type="checkbox"/> W.J. Fillmore	<input type="checkbox"/> J. Nathan	Date Received (mm-dd-yyyy)
	<input type="checkbox"/> J.M. Van Ess	<input type="checkbox"/> P. Vickers	<input type="checkbox"/> C.F. Viozzi		

Sex Assigned at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female <small>We understand this question might seem specific, but it is crucial for insurance purposes. It is designed to ensure you receive the most accurate and comprehensive coverage and care.</small>	Contact Phone	Work Phone	Date Today (mm-dd-yyyy)
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Street Address	City	State	ZIP Code
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Referring Provider Name	Phone	Fax
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Street Address	City	State	ZIP Code
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Referral Reason	Yes	No	
	Do you want implant(s) to be restored at Mayo Clinic?	<input type="checkbox"/>	<input type="checkbox"/>
	Do you want to arrange a referral to Mayo Clinic Prosthodontics?	<input type="checkbox"/>	<input type="checkbox"/>
	Is subacute bacterial endocarditis (SBE) prophylaxis needed?	<input type="checkbox"/>	<input type="checkbox"/>
	Is this patient currently taking weight loss medications?	<input type="checkbox"/>	<input type="checkbox"/>

Pertinent Medical Information	Is patient on blood thinners (anticoagulants)?	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Branemark Mk III		
	<input type="checkbox"/> NobelParallel CC		
	<input type="checkbox"/> Straumann		

R	<table border="1" style="width: 100%; text-align: center;"> <tr> <td></td><td>A</td><td>B</td><td>C</td><td>D</td><td>E</td><td>F</td><td>G</td><td>H</td><td>I</td><td>J</td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td><td>11</td><td>12</td><td>13</td><td>14</td><td>15</td><td>16</td> </tr> <tr> <td>32</td><td>31</td><td>30</td><td>29</td><td>28</td><td>27</td><td>26</td><td>25</td><td>24</td><td>23</td><td>22</td><td>21</td><td>20</td><td>19</td><td>18</td><td>17</td> </tr> <tr> <td></td><td>T</td><td>S</td><td>R</td><td>Q</td><td>P</td><td>O</td><td>N</td><td>M</td><td>L</td><td>K</td><td></td><td></td><td></td><td></td><td></td> </tr> </table>																	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						L
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<input type="checkbox"/> X-ray not available																																																																																	
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<input type="checkbox"/> X-ray sent via regular mail																																																																																	
X-rays that do not have patient name, date of birth, date of x-ray, and indicate left or right will be returned.																																																																																	

Off-hours and weekends, call 507-255-5591 and ask for oral surgeon on call.
If you have not been contacted within 1 week from above date, call 507-266-0585.

Mayo Clinic, 200 First Street SW, Rochester, MN 55905

