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HIGH DESERT
Oral & Facial Surgery

Board Certified Oral & Maxillofacial Surgeons

DATE: _____

PATIENT INFORMATION

FIRST NAME: _____ **LAST NAME:** _____

DATE OF BIRTH: _____ **CONTACT TELEPHONE:** _____

- ☐ FIRST AVAILABLE
- ☐ VERNON BURKE DMD, MD, FACS
- ☐ REO PUGAO DDS, MD, FACS
- ☐ HANS BROCKHOFF DDS, MD, FACS
- ☐ DAVID YATES DMD, MD, FACS
- ☐ NATASHA FÜRCHTGOTT DDS, MS, FACS
- ☐ BLAKE NGUYEN LAM, MD, DDS
- ☐ ARSHAD KALEEM, MD, DMD, FACS

REFERRING DOCTOR'S INFORMATION

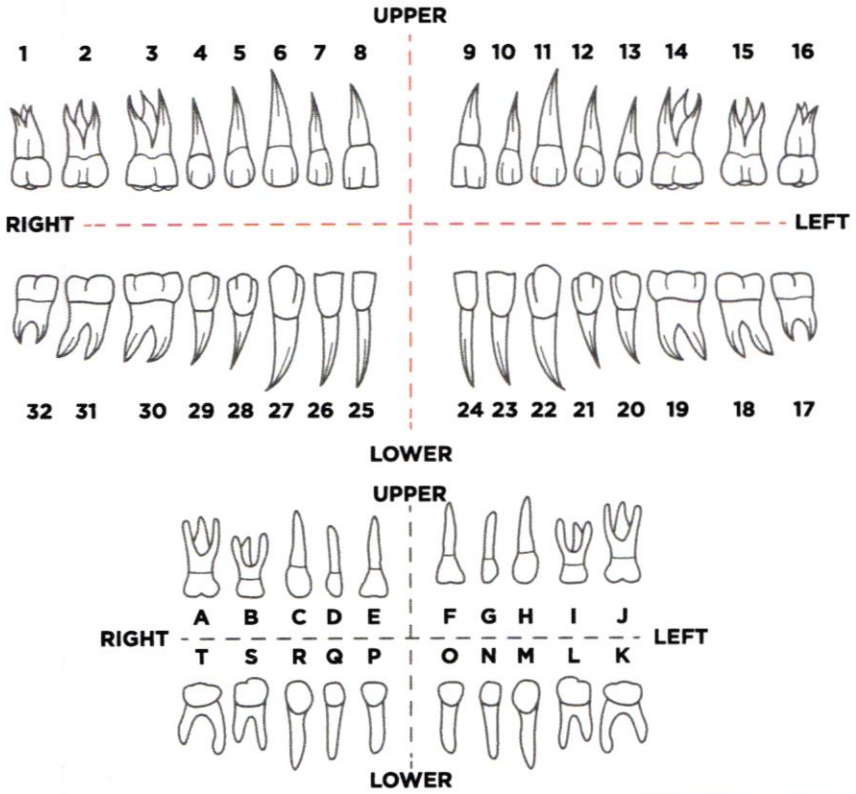
DOCTOR'S NAME: _____ **OFFICE NAME:** _____

OFFICE LOCATION: _____ **TELEPHONE:** _____
(If multiple sites)

PROCEDURES AND CONSULTATIONS

○ Alveoloplasty	○ Cleft Lip & Palate	○ Extraction (see below)	○ Orthognathic Evaluation	○ TMJ
○ Apicoectomy	○ Cosmetic	○ Frenectomy	○ Pre-Prosthetic	○ **OTHER:**
○ Biopsy	○ Expose & Bond	○ Incision & Drainage	○ Ridge Augmentation	
○ Bone Grafting	○ Exposure	○ Oral / Facial Lesion	○ Soft Tissue	

IMPLANTS: **IMPLANT SYSTEM:**



REASON:

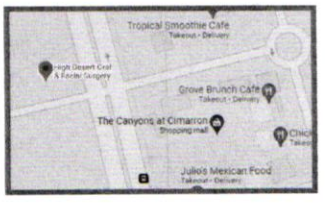
Please mark the teeth to be extracted in the diagram"

RADIOGRAPH OR CLINICAL PHOTOS

- ○ Being mailed
- ○ Given to patient
- ○ Please Take
- ○ No X-Ray

If X-Rays are attached, date in which they were taken:

10175 Gateway West Blvd., Suite 304
El Paso, Texas 79925
Phone (915) 504-6880
Fax (915) 599-8579
frontdesk@hdofs.com



1770 Cimarron Rialto Dr.
El Paso, Texas 79912
Phone (915) 833-2969
Fax (915) 833-9937
frontdesk2@hdofs.com

HIGH DESERT
Oral & Facial Surgery

☐ **HANS BROCKHOFF II DDS, MD, FACS**
Division Chief of Oral/Head & Neck Oncology and Microvascular Reconstructive Surgery
Diplomate, American Board of Oral & Maxillofacial Surgeons
Assistant Professor, Texas Tech University Health Sciences Center El Paso, TX

☐ **ARSHAD KALEEM, MD, DMD, FACS**
Head & Neck Oncology and Microvascular Reconstructive Surgeon
Board Certified Oral & Maxillofacial Surgeon

HEAD AND NECK CANCER & MICROVASCULAR REFERRAL FORM

PATIENT INFORMATION:

First Name:_____ Last Name:_____ ☐M ☐F

City, State:_____ Date of Birth:____/____/____

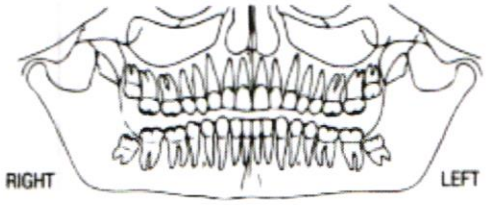
Parent/guardian name(s):_____

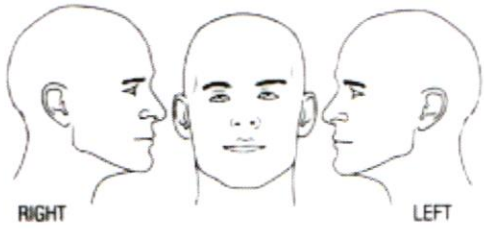
(Please check preferred contact phone number:)

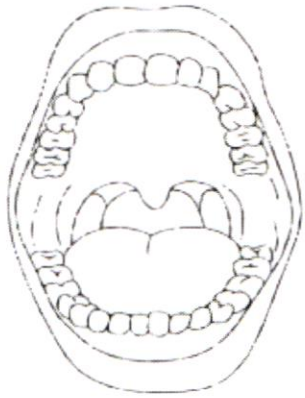
☐Home_____ ☐Cell_____ ☐Work_____

SUSPICIOUS AREA(S)

☐ Oral cavity ☐ Pharynx ☐ Lip ☐ Neck
☐ Sinus ☐ Nose ☐ Skin ☐ Scalp
☐ Mohs defect/reconstruction ☐ Salivary gland ☐ Thyroid







CLINICAL FINDINGS/SYMPTOMS

☐ Abnormal root resorption
☐ Dysphagia
☐ Hoarseness, normal CXR > 1 month
☐ Lump in neck/unresolved neck mass > 3 weeks
☐ Mass/ulcer > 3 weeks (other underlying causes ruled out)
☐ Otalgia, > 3 weeks (other underlying xauses ruled out)
☐ Red and/or white patches of oral mucosa **with bleeding/pain/swelling**
☐ Oral / Facial defect needing reconstruction
☐ Sore throat > 3 weeks. (other causes ruled out)
☐ Stridor
☐ Thyroid, solitary nodule increasing in size
☐ Ulceration of oral mucosa > 3 weeks
☐ Unexplained swelling > 3 weeks,
location:_____
☐ Unexplained tooth mobility > 3 weeks
☐ Other, note below*

* Additional concerns/comments_____

REFERRING PROVIDER INFORMATION

Name / Clinic_____

Phone No.:_____ Email:_____

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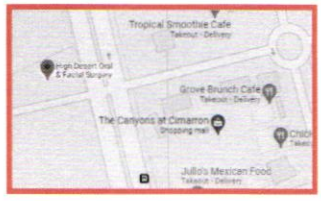

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