



**PRAIRIE**  
 Oral Surgery  
 Edward F. May, DDS

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**PATIENT REFERRAL FORM**

Patient Name: \_\_\_\_\_

Patient Address: \_\_\_\_\_

Patient Telephone: \_\_\_\_\_ Age: \_\_\_\_\_

Appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_

Evaluate for:

Extractions \_\_\_\_\_  
 Orthognathic Surgery \_\_\_\_\_ Preprosthetic Surgery \_\_\_\_\_  
 Dental Implants \_\_\_\_\_ Pathology \_\_\_\_\_  
 TMJ Disease \_\_\_\_\_ Facial Pain \_\_\_\_\_

Remarks: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

<b>R</b>										<b>L</b>					
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
					A	B	C	D	E	F	G	H	I	J	
					T	S	R	Q	P	O	N	M	L	K	

Referring Doctor: \_\_\_\_\_

Doctor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patients Referred for General Anesthesia must have:

1. Nothing to eat or drink past midnight the night prior to your appointment. Exceptions include doctor-prescribed chronic medication taken with minimal water. Please, notify our office before taking.
2. A responsible adult **MUST** accompany you, take you home, and stay with you for at least 6 hours after surgery (you cannot drive or operate machinery for 24 hours; you cannot walk, take a bus, or take a taxi home by yourself)..
3. Comfortable clothing should be worn.