North Memorial Health
Oral & Maxillofacial Surgery
Referral form

Refer to: ◯ Deepak Kademani, DMD, MD ◯ Dr. Ketan Patel, DDS, PhD ◯ First available provider

Customer information:

Customer: _____ Date of birth: _____

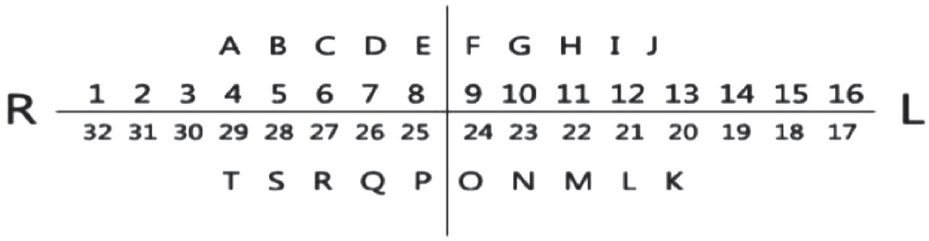
Parent/contact: _____ Phone number: _____

Please evaluate/perform the following:

◯ Lesion/biopsy(s) ◯ Orthognathic procedure ◯ TMJ/facial pain _____

◯ Trauma/facial injuries ◯ Sleep apnea surgery ◯ Other: _____

Please indicate tooth/area of concern:



Comments: _____

_____

_____

◯ Please contact customer for appointment ◯ Radiographs included ◯ Please return radiographs

◯ Customer requires interpreter (indicate language) _____

Customer has special needs: (please specify) _____

_____

Referring Provider: _____ UPIN/NPA: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Date: _____

Please note all information is required in order to process the referral!

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Robbinsdale, MN 55422
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Fax: (763) 581-5361
Email: OralMaxillofacialSurgery@Northmemorial.com
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NORTH MEMORIAL HEALTH