

PATIENT REFERRAL SLIP

**Oral and Facial Surgery Center**

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203A Energy Parkway  
Lafayette, LA 70508  
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Date \_\_\_\_\_

This is to introduce \_\_\_\_\_

Please indicate necessary treatment below:

For removal of:

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
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

If referred for another condition please list:

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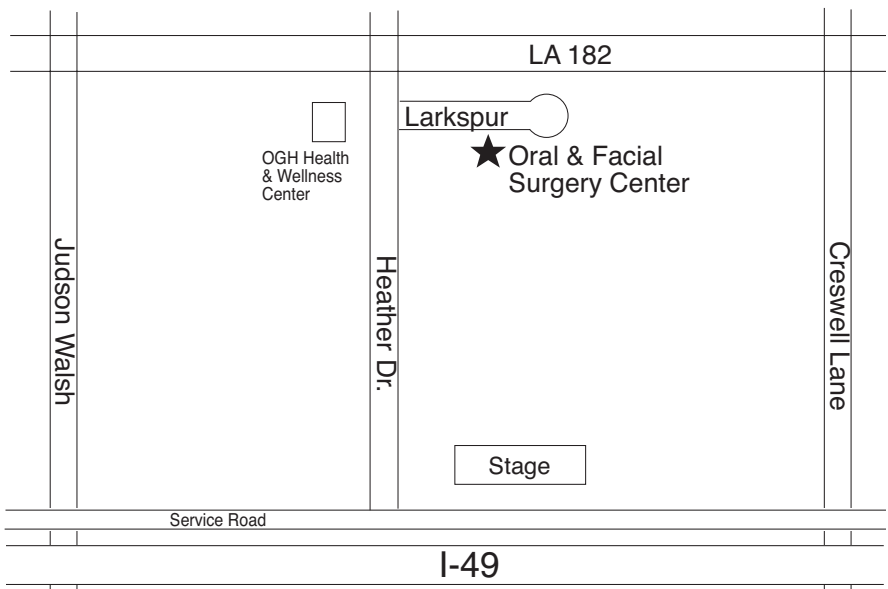
If preoperative radiographs are available please forward before appointment.

Minors must be accompanied by parents or legal guardian.

Please have patient bring this form with them at time of appointment.

Signed \_\_\_\_\_  
Referring Doctor

**LAFAYETTE LOCATION**  
**203A Energy Parkway**



**OPELOUSAS LOCATION**  
**2351 Larkspur Lane**

Exit 17

Exit 18