Children's Hospital
New Orleans
LCMC Health

Oral & Maxillofacial Surgery Referral Form

Phone: 504-894-5182
Fax: 504-867-4520
CH-OMFS@LCMChealth.org

Date of Referral: _____

Patient Information:

Patient Name: _____
Parent/Guardian Name: _____
Patient Date of Birth: _____ Phone: _____
Medical Insurance: _____Dental Insurance: _____
Member ID: _____Member ID: _____

Medical History:

_____

_____

Medications: _____

Allergies: _____

Reason / Concern for Referral:

_____

_____

_____

_____

Panoramic X-ray obtained? ☐Yes ☐No
If yes, please send panoramic x-ray to CH-OMFS@LCMChealth.org

Comments: _____

_____

Referred By:

Provider: _____

Address: _____

Phone: _____