

# Northern Rivers Oral & Maxillo-Facial Surgery

*Specialist surgery of the mouth, jaws & face*



**DR ARTHUR G BILSKI**  
Oral & Maxillo-Facial Surgeon  
MBBS (Adel) BDS (Adel) FRACGP FRACDS (OMS) FRCS (Ed)

**DR WOJCIECH M BILSKI**  
Oral & Maxillo-Facial Surgeon  
MBBS (Qld) BDS (Adel) BScDent (Hons) (Adel) FDSRCS (Eng) FRACDS FFDRCSI FRACDS (OMS)

## Patient Referral

- *Please note – to enable faster access to specialist care, patients will be offered the next available appointment with either doctor (despite which one is ticked) **unless a specific doctor is requested in a separate notation.***
- **Urgent / Emergency Referrals must be indicated in box below.**

**Dr Arthur G Bilski**

**Dr Wojciech M Bilski**

Patient name: .....

Contact Number: .....

DOB: ...../...../.....

**Reason for Referral:**

**URGENT / Emergency Referral? - Yes / No**

- |   |  |
|---|--|
| <input type="checkbox"/> Examination/Consultation | <input type="checkbox"/> Oral Pathology    |
| <input type="checkbox"/> Wisdom Teeth             | <input type="checkbox"/> Removal of Teeth  |
| <input type="checkbox"/> Dental Implants          | <input type="checkbox"/> Exposure of Teeth |
| <input type="checkbox"/> TMJ Evaluation           | <input type="checkbox"/> Infection         |
| <input type="checkbox"/> Reconstructive Surgery   | <input type="checkbox"/> Facial Trauma     |
| <input type="checkbox"/> Orthognathic Surgery     | <input type="checkbox"/> Other .....       |

**Referring Dental / Medical Practitioner name:** .....

Provider No: ..... Date of Referral: ...../...../.....

Signature (*required*): .....

***Thank you for your Referral***

Please fax or email this Referral to:

Email: [secretary@maxillofacial.com.au](mailto:secretary@maxillofacial.com.au) | Fax: 02 6622 6752

Phone: 02 6622 6750  
21 Dalley Street, East Lismore NSW 2480  
(Opposite St Vincent's Private Hospital)