



REFERRAL

THE POGUE CENTER

Cosmetic, Facial & Oral Surgery

Referring Doctor

Date

Patient Name: _____

Patient Phone Number: _____

Referring For: _____

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

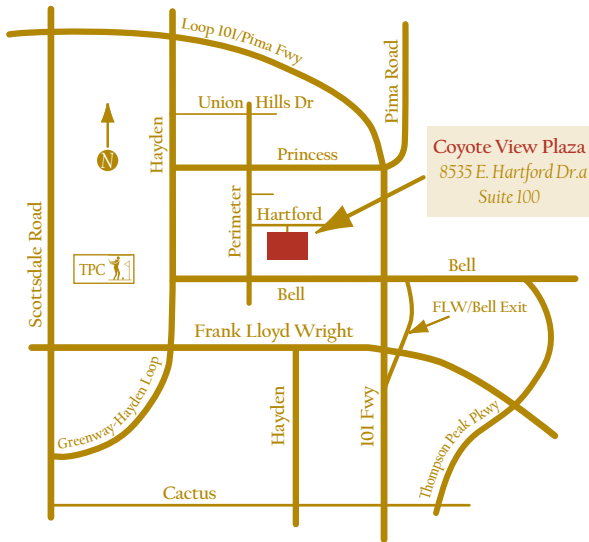
A	B	C	D	E		F	G	H	I	J
T	S	R	Q	P		O	N	M	L	K

Comments:

Radiographs: given to patient sent by mail needed

INSTRUCTIONS TO PATIENTS:

1. Please call 480-515-5400 to schedule your first appointment.
2. Generally your care is provided in three separate visits:
 - examination and consultation
 - the surgical procedure
 - an exam after surgery
3. A parent or legal guardian must accompany minors.
4. Bring this slip with you on your first visit.



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