STANDARD DENTAL REFERRAL FORM

FROM: ________________________________ TO: ________________________________
________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________

We are referring:

Patient: ________________________________ **Parent/Guardian:** ________________________

Birth date: ________________________________ **(M / D / Y)** **Telephone:** ______________________________

Address: ________________________________
____
____

Tel: ________________________________

REASON FOR REFERRAL:

❏ **CONSULTATION RE:**
____
____
____

❏ **TREATMENT (as requested):**
(Please provide specialist with appropriate details of problem; i.e. urgency, areas of concern, using F.D.I. tooth numbering system.)
____
____
____

RELEVANT HISTORY:
(Indicate any special factors – either dental or medical – such as known allergies and specific medical problems relevant to diagnosis and treatment.)
____
____
____
____
____

❏ **Please call the patient.**
❏ **Patient will call.**
❏ **An appointment has been made.**
____
❏ **Radiographs are enclosed.**
❏ **Please return radiographs after use.**
❏ **Notify on completion.**

❏ **Please report – written**
❏ **Please report – by phone**
❏ **Post-referral maintenance**
- ❏ ***By specialist***
- ❏ ***In this office***
- ❏ ***To be discussed***

❏ **Other records are available.**

SIGNED: ____ **DATE:** ______________