COSMETIC DENTAL SPECIALISTS

STANDARD DENTAL REFERRAL FORM

FROM: _____
_____
_____
_____

TO: _____
_____
_____
_____

We are referring:

Patient: _____ **Parent/Guardian:** _____

Birth date: _____ **(M / D / Y)** **Telephone:** _____

Address: _____
_____
_____

Telephone: _____

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: _____