

Referral to Dental Specialist Form

Practice Name

Practice Address

Practice Phone Number

SPECIALTY REFERRAL TO:

Introducing:

Parent/Guardian:

Birthdate:

Address:

Telephone:

REFERRED BY DOCTOR:

REASON FOR REFERRAL: Consultation Treatment

Please provide specialist with appropriate details of problem (i.e. urgency, areas of concern):

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

An appointment has been made:

Call referring doctor before treatment: Yes No

Radiographs: sent with patient mailed/transmitted attached none available

Please provide written report.

SIGNED: _____ DATE: _____

Permanent Teeth

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

Deciduous Teeth

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

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