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

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Deciduous Teeth

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