REFERRAL

PATIENT | REFERRING DOCTOR | DATE

REASON FOR REFERRAL

- ☐ Comprehensive Exam
- ☐ Limited Exam ☐UR ☐UL ☐LL ☐LR
- ☐ Crown Lengthening #
- ☐ Implant Evaluation #
- ☐ Extraction #
- ☐ Recession / Grafting #
- ☐ Ridge Augmentation #
- ☐ Frenectomy #
- ☐ Fiberotomy (CSF) #'s
- ☐ Aesthetic Recontouring #
- ☐ Expose ☐ Expose & Bond #
- ☐ Other #

BACKGROUND

Chief complaint, patient history, treatment given for current problem:

RECORDS & FOLLOW-UP

RADIOGRAPHS:

- ☐ Patient is bringing
- ☐ I am mailing
- ☐ I am e-mailing
- ☐ Take necessary radiographs

- ☐ **FMX** : Date
- ☐ **Pano** : Date
- ☐ **Bitewings**: ☐2 ☐4 Date
- ☐ **PA** : # Date
- ☐ **PA** : # Date

- ☐ Contact me prior to seeing patient.
- ☐ Contact me after your initial evaluation.
- ☐ Contact patient to schedule appointment.
  - Home
  - Cell

APPOINTMENT

☐ Date Time

☐ M ☐ T ☐ W ☐ TH ☐ F

☐ Please Call to Schedule

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