Referral Form

SMS

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Patient's Name: _____Date:_____

Appointment Date/Time: _____

Referring Doctor: _____

Refer For:

- ☐ Second Opinion
- ☐ Comprehensive Care
- ☐ Limited Scope Care (in tx section)
- ☐ Call Referral Prior to Beginning Treatment
- ☐ CBCT Only (disk copy given to patient)
- ☐ Other: _____

Prosthodontic Treatment:

Fixed Prosthodontics	**Tooth#(s)**
☐ Functional Rehabilitation	_____
☐ Esthetic Rejuvination	_____
☐ Perio/Pros Rehabilitation	_____
☐ Failing Dentition	_____
☐ Other: _____	

Radiographs

- ☐ Take All Necessary
- ☐ Mailed/ Emailed
- ☐ Patient Will Bring

Maintenance

- ☐ Return for Comp Care
- ☐ Return for Hygiene Only
- ☐ Patient Released

Implant Prosthodontics	**Tooth# (s)**
☐ Single Tooth Replacement	_____
☐ Multiple Tooth Replacement	_____
☐ Implant Supported Dentures	_____
☐ Tooth/Soft Tissue Recon.	_____
☐ Malpositioned Implant Recon.	_____

Please Evaluate Patient For:

Condition	**Tooth #(s)/Area**
☐ Esthetic Evaluation	_____
☐ Wear/Erosion	_____
☐ Vertical Dimension Compromise	_____
☐ Failing Fixed Prosthetics	_____
☐ Rampant Caries	_____
☐ Tooth Restorability	_____
☐ Matching Single Central/Anterior Tooth	_____
☐ Missing Tooth/Teeth	_____
☐ Dental Implant Therapy	_____
☐ Fractured/Ill-fitting Removable Prosthetic	_____
☐ Sleep Apnea	_____
☐ TMJ Disorder	_____
☐ Oral/Maxillofacial Defect/Disorder	_____
☐ Other: _____	