FROM: TO:

We are referring:

Client:

Birthdate:

Address:

Parent/Guardian:

Telephone:

Email:

REASON FOR REFERRAL: (Please provide details of concern.)

❑ CONSULTATION:

❑ TREATMENT:

RELEVANT HISTORY: (Please indicate known allergies and specific medical/dental problems relevant to diagnosis and treatment.)

❑ Please call the client ❑ Client will call ❑ An appointment has been made: _____

❑ Radiographs are enclosed ❑ Please return radiographs after use ❑ No current radiographs available

Notify on completion: ❑ in writing ❑ by phone

Post-referral maintenance: ❑ by specialist ❑ in this office ❑ to be discussed

SIGNED: _____DATE: _____