Specialty Referral Form

Patient _____ Referring Dr. _____ Date _____

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

For OS: Has PANO been taken? ☐ Yes ☐ No

- ☐ Surgical Rem of Erupted Th #_____
- ☐ Soft Tissue Impaction Th #_____
- ☐ Partial Bony Impaction Th #_____
- ☐ Full Bony Impaction Th #_____
- ☐ Basic Ext of Erupted Th #_____
- ☐ Root tip Extraction Th #_____
- ☐ Consultation only
- ☐ Alveoplasty
- ☐ Bone Graft
- ☐ Removal of Tori (Quad_____)
- ☐ Frenectomy
- ☐ Other _____

For ENDO: Tooth# _____

- ☐ RCT
- ☐ O&M done
- ☐ Consultation only (NO Treatment)
- ☐ Call GP Prior to Starting Treatment
- ☐ Diagnosed Crown Lengthening
- ☐ Post Space / Build up
- ☐ Other _____

Recommended Final Restoration: ☐ Crown (type) _____ ☐ Bridge ☐ Filling

For PERIO:

- ☐ Perio Evaluation
- ☐ Osseous Surgery + Bone Graft
- ☐ Ext + Bone Graft Th #_____
- ☐ Ridge Augmentation_____
- ☐ Dates of SRPs:_____
- ☐ Crown Lengthening Th #_____
- ☐ Tissue Graft Th #_____
- ☐ Implant Th #_____
- ☐ Other _____

Has the pt had previous periodontal surgery? Y N How long ago?_____

Has the pt been advised of possible extractions? Y N Th #_____

For ORTHO: Has PANO been taken? ☐ Yes ☐ No

- ☐ Crowding
- ☐ Growth Pattern
- ☐ Spacing
- ☐ Patient wants straighter smile
- ☐ Malocclusion – (Open Bite, Cross Bite, Deep Bite, Protruded Teeth)
- ☐ Other _____

Comments _____

_____

Referring Dr Signature _____ Date _____

Comments from Specialist _____

_____

Specialist Signature _____ Date _____