STANDARD DENTAL REFERRAL FORM

APPROVED BY THE CANADIAN DENTAL ASSOCIATION

FROM:

TO:

We are referring:

Patient: ______________________________

Parent/Guardian: ______________________________

Birthdate: ______________________________ (M / D / Y)

Telephone: ______________________________

Address: ______________________________

____

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Telephone: ______________________________

REASON FOR REFERRAL:

❑ **CONSULTATION RE:**

❑ **TREATMENT (as requested):**
(Please provide specialist with appropriate details of problem; i.e. urgency, areas of concern, using F.D.I. tooth numbering system.)

RELEVANT HISTORY:

(Indicate any special factors – either dental or medical – such as known allergies and specific medical problems relevant to diagnosis and treatment.)

❑ **Please call the patient.**
❑ **Patient will call.**
❑ **An appointment has been made.**
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❑ **Radiographs are enclosed.**
❑ **Please return radiographs after use.**
❑ **Notify on completion.**

❑ **Please report – written**
❑ **Please report – by phone**
❑ **Post-referral maintenance** ❑ ***By specialist***
❑ ***In this office***
❑ ***To be discussed***
❑ **Other records are available.**

SIGNED: ______________________________ **DATE:** ______________________________