

# DENTAL SPECIALIST REFERRAL

DATE OF REFERRAL  
PRIORITY LEVEL

Routine  
Urgent

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REFERRING DENTIST  
PRACTICE NAME/PHONE  
REFERRED SPECIALIST  
SPECIALTY (ENDO/PERIO/OMS/ORTHO)

PATIENT INFORMATION  
FULL NAME  
DATE OF BIRTH / PHONE

REASON FOR REFERRAL / CLINICAL FINDINGS  
TOOTH NUMBER(S) / QUADRANT  
ATTACHMENTS INCLUDED

Radiographs (X-Rays)  
Clinical Photos  
Medical History  
CBCT Scan  
Lab Reports  
Periodontal Charting

REFERRING DOCTOR SIGNATURE  
LICENSE NUMBER