CEDAR POINTE
PROSTHODONTICS

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Board Certified Prosthodontist
DDS, Cert. Pros, FRCD(C)

PATIENT REFERRAL FORM

PATIENT INFORMATION

Patient Name: _____ Gender: ☐ M ☐ F
Address: _____
Date of Birth: _____ Patient Phone: _____
Guardian Name: _____ Guardian Phone: _____

REASON FOR REFERRAL

Consultation Regarding (please indicate specific region using FDI notation):

☐ Compromised Aesthetics
☐ Compromised Function
☐ Comprehensive Care
☐ Specific Region / Other: _____
☐ Fixed Prosthetics (Veneer, Onlay, Crown, Bridge)
☐ Removable Prosthetics (Partial, Complete, Overdenture)
☐ Implants (☐ Placement Only ☐ Place & Restore)

TREATMENT (as requested)

Please provide the specialist with appropriate details of problem (ie, urgency, areas of concern, etc.)

_____

SIGNIFICANT MEDICAL & DENTAL HISTORY

Indicate any special factors (ex: allergies, medical problems, medications) relevant to diagnosis and treatment

_____

RADIOGRAPHS

☐ E-mailed (Preferred) ☐ Enclosed ☐ Mailed ☐ Faxed ☐ With Patient ☐ None

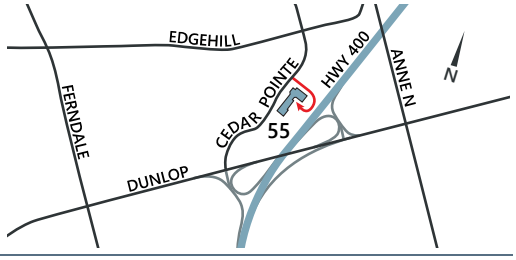
APPOINTMENT

☐ Already scheduled ☐ Contact patient to schedule ☐ Patient will call

POST-CONSULTATION ACTION

☐ DO NOT TREAT; Report findings and proposed plan to referring doctor: ☐ in writing ☐ by phone
☐ Report findings and proposed plan to referring doctor prior to treatment: ☐ in writing ☐ by phone
☐ Treat as needed; No need to follow-up with referring doctor

Date of Referral: _____
Referring Doctor: _____
Office: _____
Phone: _____
E-mail: _____



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