STANDARD DENTAL REFERRAL FORM

APPROVED BY THE CANADIAN DENTAL ASSOCIATION

FROM: _____ **TO:** _____

_____ _____

_____ _____

_____ _____

We are referring:

Patient: _____ **Parent/Guardian:** _____

Birthdate: _____ **Telephone:** _____
(M / D / Y)

Address: _____

_____

_____

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.**
_____
❑ **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:** _____