

Date: \_\_\_\_\_

Referring Office: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Office Number: \_\_\_\_\_



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



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



**Endodontic Referral:**

- Toothache/ Pain/Swelling
- Pulp Exposure/Previous Pulpotomy/RCT
- Endodontic Necessary for Proper Restoration
- Periapical Pathosis
- CBCT - 3D Scan
- Other (comment below)

**Restoration Type:**

- Cavit/IRM/Temp Filling
- Prepare Post Space
- Core Build-up/Composite
- Cement Post & Core Build Up

**Oral Surgery Referral:**

- Implant(s)
- Inclusive Restoration Protocol - Comment shade below
- Referring dentist to place abutment
- Extraction (s)
- Wisdom Teeth
- Bone Grafting
- Alveoloplasty
- Lesion Evaluation
- Expose & Bond
- Frenectomy
- TMJ
- All-on-X
- Other (comment below)

**Comments:** \_\_\_\_\_

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