Orthodontic Referral

Specialist Name: ____________________

Address: ____________________

____

Patient Name: ____________________

Referring Doctor: ____________________

Phone Number: ____________________

FAX Number: ____________________

Appointment Date: ____________________

Appointment Time: ____________________

Phone Number: ____________________

CALL REFERRING DOCTOR BEFORE TREATMENT: YES ❑ / NO ❑

SPECIFIC AREAS OF CONCERN:

- ❑ Over-Bite
- ❑ Open-Bite
- ❑ Thumb-Sucking
- ❑ Tongue Thrusting
- ❑ Protrusion
- ❑ Diastema
- ❑ Other ____________________
- ❑ Crossbite
- ❑ Crowding
- ❑ Space Deficiency
- ❑ Space Maintenance
- ❑ Impaction(s) ____________________
- ❑ Congenitally Missing Teeth ____________________
- ❑ Facial Orthopedics
- ❑ Orthognathic Surgery
- ❑ TMJ Pain/Dysfunction
- ❑ Restorative/Prosthetics

INSTRUCTIONS/REMARKS:

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Doctor Signature Date

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INSTRUCTIONS

Complete and sign the referral form. Then send to the doctor via one of the following options:

1. Email: Fill out the form. Print.
    - Scan the completed form and save as a JPEG or PDF file.
    - Open your email client and attach the saved (scanned) document.
    - Send to the Office Email address.

2. Print the form. Then, Fax it to the doctor’s office (fax number on page 1 of this form or on the DSI website).

3. Print the form. Then, Mail it to the doctor’s office (address on page 1 of this form or on the DSI website).

4. Print the form. Give to the patient to deliver to the doctor’s office.