



Prosthodontic Referral

Specialist Name: _____ Phone Number: _____
 Address: _____ FAX Number: _____
 _____ Appointment Date: _____
 Patient Name: _____ Appointment Time: _____
 Referring Doctor: _____ Phone Number: _____

CALL REFERRING DOCTOR BEFORE TREATMENT: YES / NO

TEETH IN QUESTION:

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	32	31	30	29	28	27	26	25		24	23	22	21	20	19	18	17	

Referred For:

- Implants
- Fixed Pros
- Removable Pros
- TMJ
- Consultation Only
- Other _____

REMARKS: _____

Doctor Signature

Date

Confidentiality Notice: Health care information is confidential; federal and state law prohibits disclosure without patient consent. The information contained in this form may be confidential, proprietary and/or legally privileged information intended only for the use of the individual or entity named above. If the reader of this document is not the intended recipient, you are hereby notified that any copying, dissemination or distribution of confidential, proprietary or privileged information is strictly prohibited. If you have received this document in error, please immediately notify the sender and destroy all information received.

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.