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& Associates

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Referral Form

Name of Doctor Making Referral: _____

Telephone number of Doctor: _____

Name of Patient Being Referred: _____

Telephone Number of Referred Patient: _____

Date of Referral: _____

REFERRING DOCTOR: *Please check all of the services that were completed in your office.*

( ) examination ( ) emergency examination only ( ) radiographs (please share)

( ) prophylaxis ( ) other: _____

( ) prescription given: _____
(drug and amount)

Reason for Referral:

( ) child's young age ( ) child's behavior ( ) extent of work needed

( ) developing malocclusion ( ) other: _____

Would like Dr. Gutenberg or Associate to:

( ) provide comprehensive care

( ) treat only the following tooth/teeth: _____

_____

After the restorative treatment is complete:

( ) please refer this child back to our office for routine care

( ) please continue check-up visits in your pediatric office