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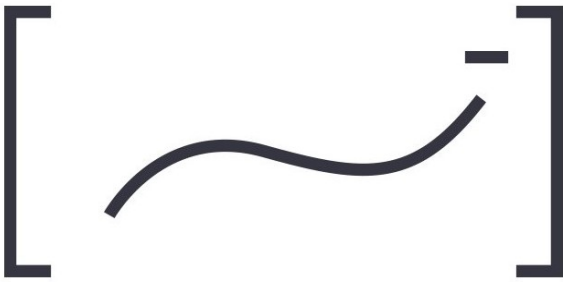

Prosthodontic Referral Form

Today's Date: (DD/MM/YY): _____

Patient name: (Ms. Miss. Mrs. Mr. Dr.) _____

D.O.B (DD-MMM-YY): _____

Home Phone: ( ) _____ Cellular Phone: ( ) _____

E-mail: _____

Referral Details (Please ☒ check or circle the reason(s) for referral)

☐ Complete Prosthodontic care ☐ Dental Implants ☐ Crown & Bridge ☐ Removable Dentures

☐ Other or limited prosthodontic care (please explain): _____

_____

_____

_____

_____

Radiographs included: ☐ Bitewings ☐ Periapicals ☐ Panoramic ☐ Other: _____

Study casts included: ☐ yes ☐ no CBCT Scan Records: ☐ yes ☐ no

Referring Dentist: _____ Phone: ( ) _____

Address: _____ Fax: ( ) _____

_____ Email: _____

Requested Report by: ☐ Telephone ☐ Letter ☐ E-mail