



# STANDARD DENTAL REFERRAL FORM

APPROVED BY THE CANADIAN DENTAL ASSOCIATION

FROM: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

TO: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**We are referring:**

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

Parent/Guardian: \_\_\_\_\_

Birthdate: \_\_\_\_\_  
(M / D / Y)

Telephone: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_

**REASON FOR REFERRAL:**

CONSULTATION RE: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

TREATMENT (as requested):  
*(Please provide specialist with appropriate details of problem; i.e. urgency, areas of concern, using F.D.I. tooth numbering system.)*  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**RELEVANT HISTORY:**

*(Indicate any special factors – either dental or medical – such as known allergies and specific medical problems relevant to diagnosis and treatment.)*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- Please call the patient.
- Patient will call.
- An appointment has been made.  
\_\_\_\_\_
- Radiographs are enclosed.
- Please return radiographs after use.
- Notify on completion.

- Please report – written
- Please report – by phone
- Post-referral maintenance  *By specialist*  
 *In this office*  
 *To be discussed*
- Other records are available.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_