Irvin Orthodontics

Alan W. Irvin, DDS MSD
Amir Aminoshariae, DMD MS MSD

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.

❑ Please report – written
❑ Please report – by phone
❑ Post-referral maintenance

❑ Other records are available.

❑ *By specialist*
❑ *In this office*
❑ *To be discussed*

❑ Radiographs are enclosed.
❑ Please return radiographs after use.
❑ Notify on completion.

SIGNED: _____ **DATE:** _____