



A thoughtful handoff for your patient

Complete this form digitally or print it. Our team will coordinate the next step with your office.

01 Patient and referring practice

PATIENT NAME

DATE OF BIRTH

PATIENT PHONE

REFERRING CLINICIAN / PRACTICE

OFFICE PHONE

SECURE FAX / CONTACT

02 What would you like us to evaluate?

☐ Consultation ☐ Treatment ☐ Second opinion ☐ Time sensitive

REASON FOR REFERRAL AND AREA OF CONCERN

RELEVANT DENTAL / MEDICAL CONTEXT FOR THIS CONSULTATION

03 Records and coordination

☐ Radiographs ☐ Photographs ☐ Scans / models ☐ Clinical notes

☐ Records to follow ☐ Please call before treatment

☐ Please send a report ☐ Patient has been informed of referral

BEST CONTACT AT REFERRING OFFICE

REFERRAL DATE

PREFERRED CALLBACK

Sending the referral

Please call (714) 974-0949 to confirm the office's current referral channel and coordinate any records needed for the consultation.

This PDF is a fillable document; downloading it does not transmit it to the practice.