SIMPLYBRACES

SPECIALIST ORTHODONTIST

REFERRAL FORM

Referring Practitioner

Doctor: _____

Tel: _____

Address: _____

_____

_____

Patient

Name: _____

Date of birth: _____

Tel: _____

Address: _____

_____

Purpose of Referral

- ☐ Consultation and treatment
- ☐ Second orthodontic opinion
- ☐ Consultation only(possible treatment by general practitioner)
- ☐ Assessment for interdisciplinary treatment

Others: _____

_____

_____

_____

Dental Status

Caries Risk ☐ High ☐ Medium ☐ Low

Oral Hygiene ☐ Good ☐ Fair ☐ Poor

Relevant Medical History ☐ Nil ☐ Yes

Teeth with Questionable/Poor Prognosis: _____

- ☐ Patient is dentally fit for orthodontic treamtemt
- ☐ Radiographs enclosed ☐ OPG ☐ Lat. Ceph. ☐ Others

Main Concern: _____

_____

Comments: _____

_____

Signature: _____ Date: _____

Patient:Please bring this referral letter with you to your consultation.

SIMPLYBRACES

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