Parkway Dental Care & Orthodontics

Hooman Lohrasbi DDS
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469-587-6364

Referral Form

FROM: _____ TO: _____

Referring Doctor Telephone: _____ Referring Doctor Email: _____

WE ARE REFERRING:

Patient: _____ Birthdate: _____

Telephone: _____ Email: _____

Address:_____

Parent/Guardian: _____ 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.**

Signature: _____ Date:_____