Hunter Valley® ORTHODONTICS

A CONFIDENT SMILE IS YOUR GREATEST ASSET

Referring Dentist ______________________________ Referral Date ____________________

Practice Name ____

Practice Address ____

Patient Name ______________________________ Date of Birth ____________________

Patient Address ____

____ Patient Phone ____________________

I am referring the above patient to you for:

- ◯ Crowding ....
- ◯ Rotations ....
- ◯ Overjet ....
- ◯ Overbite ....
- ◯ Openbite ....
- ◯ Crossbite ....
- ◯ Impacted Teeth ....
- ◯ Skeletal Discrepancy ....
- ◯ Missing Teeth ....
- ◯ Supernumerary Teeth ....
- ◯ Ankylosed Teeth ....
- ◯ Second Opinion ....
- ◯ X-rays ....
- ◯ Possible Retreat ....
- ◯ Other - Comments ....

....

....

◯ I enclose radiographs for this patient.

I request the following action(s) to be taken:

- ◯ Treat and report
- ◯ Assess and discuss this patient with the referring dentist

Comments ....

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Office Use Only

Patient Consultation Date: .... Date Patient Pack Sent: .... Staff Initial: ....

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