Dr. Edmond Ghiabi, *Periodontist*
Dr. Negin Ghiabi, *Pediatric Dentist*

PINNACLE
DENTAL SPECIALISTS

Referral Form

FROM: _____ **TO:** _____

_____ _____

_____ _____

_____ _____

We are referring:

Patient: _____ **Parent/Guardian:** _____

Birthdate: _____ **Telephone:** _____
(M / D / Y)

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.**
_____
❑ **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.**

SIGNED: _____ **DATE:** _____

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