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Date: _____

Referring Doctor: _____

My Patient _____ is referred to you because of the following problem and/or reason:

_____

_____

_____

Please be aware that the patient has the following medical condition which might affect your treatment:

_____

The patient does / does not need prophylactic antibiotic therapy prior to treatment:

_____

Date _____ Day _____ Time _____

Copies of the enclosed include:

❑ Panorex X-ray Date _____ Other *(Specify)* _____
❑ PA or BW X-ray Date _____ _____

I will / will not continue to follow the patient for:

❑ General Prophylaxis ❑ Recall Exam
❑ Other *(Specify)* _____

At the conclusion of therapy, please refer / do not refer patient back to me.

❑ Please Call
❑ Send written report

Signed _____
Referring Doctor

www.binondentalimplants.com

Pacific Coast Society for Prosthodontics

FELLOW Academy of Osseointegration

ACP AMERICAN COLLEGE OF PROSTHODONTISTS