AMERICAN CANYON
ORTHODONTICS
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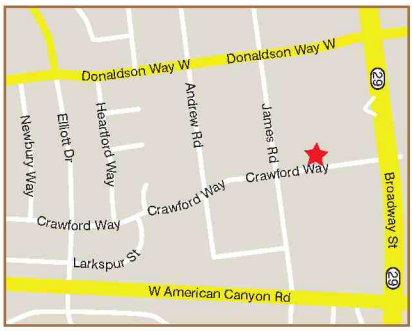

REFERRAL SLIP

Date _____

I HAVE REFERRED

_____ AGE _____

PHONE: _____

TO YOUR OFFICE FOR:

- ☐ INITIAL ORTHODONTIC EXAM
- ☐ SPACE AND GROWTH EVALUATION
- ☐ ORTHODONTIC TREATMENT AS A COMPONENT OF MULTIDISCIPLINARY CARE
- ☐ OTHER _____

_____

DENTAL RESTORATIVE AND PERIODONTAL STATUS:

- ☐ PATIENT IS CLEAR TO START ORTHODONTIC TREATMENT
- ☐ PATIENT HAS REMAINING CARIES TO BE RESTORED PRIOR TO STARTING ORTHODONTIC TREATMENT
- ☐ PATIENT IS ON A MAINTENANCE ROUTINE FOR PREVIOUSLY ACTIVE PERIODONTAL DISEASE
- ☐ PATIENT HAS RESTORATIVE NEEDS THAT MAY BE INFLUENCED BY THE ORTHODONTIC TREATMENT PLAN

COMMENTS: _____

_____

_____

REFERRED BY DR. _____

PHONE: _____

DATE _____

PLEASE INFORM YOUR PATIENT
THERE IS NO CHARGE FOR THE
INITIAL EXAM

Member American Association of Orthodontists

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