PROSTHODONTICS REFERRAL FORM

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PROSTHODONTIST

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Referring Dentist's Name: _____ **Phone #:** _____ **Fax #:** _____

Patient's Name: _____ **Patient's Phone #:** _____

Chief Concern or Complaint: _____

Past Dental History: _____

Special Concerns: _____

Prosthodontic Care That May Be Required: (check the boxes that apply for this patient)

Removable Prosthodontics:

- ❑ Complete denture (*circle one*: upper lower both)
- ❑ Partial denture (*circle one*: upper lower both)
- ❑ Immediate / Interim denture (*circle one*: upper lower both)
- ❑ Overdenture (*circle one*: upper lower both)
- ❑ Emergency:
  - ❑ Broken denture base
  - ❑ Broken denture tooth
  - ❑ Broken clasp
- ❑ Reline to existing denture
- ❑ Other (specify): _____

Fixed Prosthodontics:

- ❑ Crown: #_____
- ❑ Bridge (fixed partial denture): #_____
- ❑ Post and core or build-up: #_____
- ❑ Veneer: #_____
- ❑ Inlay: #_____
- ❑ Onlay: #_____
- ❑ Emergency (specify): _____
- ❑ Other (specify): _____

Implant Prosthodontics:

- ❑ Single tooth implant #_____
- ❑ Multiple teeth implants #'s_____
- ❑ Implant supported dentures

Reconstruction (*circle one*: full-mouth or partial-mouth)

- ❑ Teeth involved #_____

Patient's vertical dimension of occlusion is:

- ❑ Excessive (needs to be decreased)
- ❑ Reduced (needs to be increased)

Miscellaneous:

- ❑ Demanding patient (give brief history): _____
- ❑ TMD complaint (give brief history): _____

PLEASE FAX OR MAIL COMPLETED REFERRAL FORM TO:

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