



# REFERRAL FORM

Thank you for trusting us with your patient's care. We provide focused surgical and prosthetic care, while routine hygiene and restorative dentistry remain with the patient's dental home.

## REFERRING OFFICE

DOCTOR / PRACTICE

PHONE

EMAIL

## PATIENT

NAME

DATE OF BIRTH

PHONE

EMAIL

## REFERRAL REQUEST

ARCH

☐ Maxillary

☐ Mandibular

☐ Both

REFERRAL TYPE

☐ Surgical

☐ Prosthetic

☐ Both

### CLINICAL QUESTION / REQUEST DETAILS

Describe the concern, relevant sites, desired outcome, and how this fits your plan.

### IF PROSTHETIC

☐ Complete denture

☐ Partial denture

☐ Implant overdenture / partial

☐ AOX fixed full-arch

☐ Other

## MEDICAL HISTORY + OTHER NOTES

Significant conditions or medications, urgency, accessibility needs, or other relevant information.

## COORDINATION + RECORDS

### WHO SHOULD RESTORE THE PROSTHETIC?

☐ Oak Mountain

☐ Referring office

☐ Please coordinate with us

### RECORDS ATTACHED

☐ Radiographs

☐ CBCT / DICOM

☐ Photos

☐ None - please obtain

## RETURN FORM + RECORDS

smile@omdentures.com | (205) 677-5111

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Please use your office's secure method when transmitting patient information.