Referral Slip

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Phone 541.359.3261
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Date _____

Referring Doctor _____ **Office Number** _____

Office Email _____ **Office Fax** _____

Name of Patient _____ **Age**____ **Phone** _____

Responsible Name _____ **RP Email** _____

- ☐ Growth Modification
- ☐ Crowding
- ☐ Spacing
- ☐ Crossbite
- ☐ Deep Bite
- ☐ Open Bite
- ☐ Class II
- ☐ Class III
- ☐ Thumb/Finger Habit
- ☐ Tongue Tie
- ☐ Tongue Thrust
- ☐ Tooth Alignment
- ☐ Restorative Needs ☐ Yes ☐ No
- ☐ Panoramic X-Ray Taken ☐ Yes ☐ No
- ☐ Cleared for Orthodontics ☐ Yes ☐ No
- ☐ Other Remarks (Please specify)

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Thank you for referring us your patient for orthodontic treatment. We look forward to working with you and your staff to provide the best treatment possible. To help us be more prepared for our consult, please provide the following information regarding your patient. Thank you!

Please email referrals to smile@oregonfamilyortho.com