**DENTAL REFERRAL SLIP**

**Date:**\_\_\_\_\_\_\_

**Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Birthday:**\_\_\_\_\_\_\_\_\_

**Course/Level/Section:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Age**:\_\_\_\_\_ **Sex**:\_\_\_\_\_

**Address**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Recommendation for:**

**( ) Oral Prophylaxis ( ) Restoration Tooth #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**( ) Treatment of gingivitis ( ) Extraction Tooth #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**( ) X-Ray Tooth #** \_\_\_\_\_\_\_ **( ) Root Canal Therapy Tooth #** \_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_ **Periapical** \_\_\_\_\_\_\_ **Panoramic**

\_\_\_\_\_\_\_\_ **Cephalmetric**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**School Dentist**

**License No:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**