



PROSTHODONTICS
on chamberlain

Dr. Stewart K. Hum
PROSTHODONTIST
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PATIENT REFERRAL FORM

DATE _____ REFERRING DOCTOR _____

PATIENT NAME _____

ADDRESS _____

PHONE _____

- PATIENT IS APPOINTED ON:
 PLEASE CONTACT THE PATIENT PATIENT WILL CONTACT YOUR OFFICE

PROPOSED PROSTHETIC MANAGEMENT:

- | | |
|---|--|
| <input type="checkbox"/> RESTORATIVE CARE / CROWN(s) | <input type="checkbox"/> FIXED BRIDGE(s) |
| <input type="checkbox"/> POST & CORE | <input type="checkbox"/> PARTIAL DENTURE(s) |
| <input type="checkbox"/> VENEERS / ONLAY / INLAY | <input type="checkbox"/> IMMEDIATE DENTURE(s) |
| <input type="checkbox"/> PERIODONTAL SPLINT | <input type="checkbox"/> COMPLETE DENTURE(s) |
| <input type="checkbox"/> IMPLANT-FIXED PROSTHESIS | <input type="checkbox"/> OVERDENTURE(s) |
| <input type="checkbox"/> IMPLANT-REMOVABLE PROSTHESIS | <input type="checkbox"/> TMD / OCCLUSAL SPLINT |
| <input type="checkbox"/> IMPLANT FIXED-REMOVABLE PROSTHESIS | <input type="checkbox"/> PROSTHETIC REPAIR |
| <input type="checkbox"/> COMPREHENSIVE PROSTHETIC REHABILITATION / ASSESSMENT | |

PURPOSE OF CONSULTATION/ASSESSMENT:

SIGNIFICANT MEDICAL/DENTAL HISTORY:

EXISTING PERIODONTAL THERAPY:

3 4 6 9 12 -MONTH RECALL _____

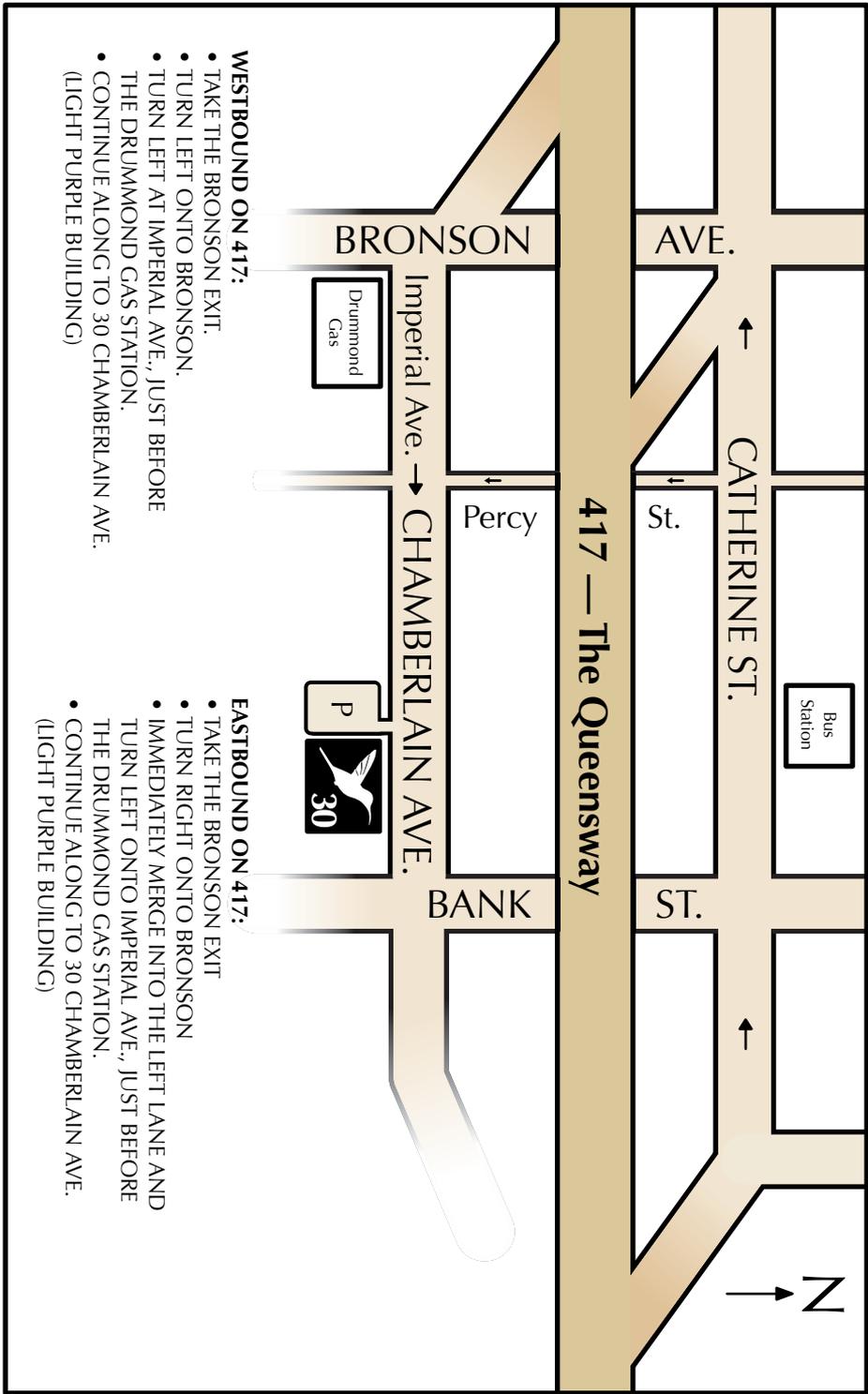
RADIOGRAPHS/STUDY MODELS:

- DUPLICATES ENCLOSED WILL BE FORWARDED PLEASE RETURN ORIGINALS

CONSULTATION REPORT: IN WRITING BY PHONE

- PROCEED WITH APPROPRIATE TREATMENT _____
- PROCEED WITH ADDITIONAL REFERRALS / CONSULTATIONS AS NEEDED _____

Dentist Signature: _____



WESTBOUND ON 417:

- TAKE THE BRONSON EXIT.
- TURN LEFT ONTO BRONSON.
- TURN LEFT AT IMPERIAL AVE., JUST BEFORE THE DRUMMOND GAS STATION.
- CONTINUE ALONG TO 30 CHAMBERLAIN AVE. (LIGHT PURPLE BUILDING)

EASTBOUND ON 417:

- TAKE THE BRONSON EXIT
- TURN RIGHT ONTO BRONSON
- IMMEDIATELY MERGE INTO THE LEFT LANE AND TURN LEFT ONTO IMPERIAL AVE., JUST BEFORE THE DRUMMOND GAS STATION.
- CONTINUE ALONG TO 30 CHAMBERLAIN AVE. (LIGHT PURPLE BUILDING)