SafeGuard®

Direct Referral Form

Referring Dentist - In order to ensure proper communication, ALL information must be filled out accurately and completely. Appropriate radiographs should be placed in the envelope & forwarded to the specialist.

Referring Dentist Information: Facility number:_____

Name:_____

Phone:_____

Specialist Information: Facility number:_____

Name:_____

Address:_____

City:_____ ZIP:_____ Phone:_____

Patient Information: Family ID number:_____

Name:_____

DOB:_____

Subscriber Name:_____

Clinical Information:

Referral type: [ ] Oral Surgery [ ] Endodontics
[ ] Pedodontics [ ] Periodontics

Tooth number/area in question: _____

Reason for referral:

_____

_____

_____

_____

_____

_____ _____

Referring Dentist Signature Date

SG-DR-FORM-CA