Special Smiles LTD.
Comprehensive dental care for persons with special needs

2301 E. Allegheny Ave., Suite 120, Philadelphia, PA 19134
267.639.6250 (phone), 267.639.6270 (fax), email: i.gardner@specialsmilesltd.com

SPECIAL SMILES REFERRAL

PATIENT NAME: _____ **DOB:** _____

FACILITY/HOME: _____

ADDRESS: _____

_____

PHONE/FAX: _____

DENTIST (IF KNOWN) _____

.....

REASON FOR REFERRAL FOR TREATMENT UNDER GENERAL ANESTHESIA: _____

_____

TEETH TO BE WORKED ON (IF APPLICABLE):

				A	B	C	D	E	/	F	G	H	I	J			
Patients Right	1	2	3	4	5	6	7	8	/	9	10	11	12	13	14	15	16 *Patients Left*

32	31	30	29	28	27	26	25	/	24	23	22	21	20	19	18	17	
			T	S	R	Q	P	/	O	N	M	L	K				

RADIOGRAPHS:

❑ **Please take/send copy** ❑ **Patient will bring copy** ❑ **I will send/Please return**

REFERRING DENTIST'S RECOMMENDATIONS: _____

_____

_____

❑ **Patient will stay at Special Smiles for future treatment**

❑ **Patient will return to referring dentist for future treatment**

DENTIST (PRINT): _____

DENTIST (SIGNATURE): _____

DATE: _____