Lancaster Cleft Palate Clinic

DENTAL REFERRAL

Date_____ DOB _____

Patient's Name _____ Phone _____

Medical History/Allergies/Medications _____

_____

I have referred our patient to your office for:

A B C D E F G H I J

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

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

o Consultation Only **o Restorative** **o Other**

_____

_____

_____

Diagnosis _____

Xrays **o enclosed** **o patient will bring** **o will be sent** **o please take**

Please consult and perform the procedure above if deemed possible after your evaluation and update us with your feedback on this case. Thank you for your time to attend to our patient.

Sincerely,

Helping children and adults achieve a bright and happy future since 1938.
A Private Nonprofit Organization Founded by Dr. H.K. Cooper, Sr.

223 North Lime Street, Lancaster, PA 17602 (717) 394-3793 (717) 396-7409 Fax

Please send referrals to: frontdesk@cleftclinic.org