TSAI ORTHODONTICS

CERTIFIED SPECIALIST IN ORTHODONTICS

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ORTHODONTIC REFERRAL

URGENCY ☐ Routine ☐ Within 1 month ☐ Urgent - please call

PATIENT

PATIENT NAME

DATE OF BIRTH

PHONE

EMAIL

GENDER

PARENT / GUARDIAN NAME

LANGUAGE PREFERENCE ☐ English ☐ Mandarin ☐ Cantonese

REFERRING DOCTOR / PRACTICE

REFERRING DOCTOR / PRACTICE

OFFICE PHONE

DATE OF REFERRAL

OFFICE EMAIL

REASON FOR REFERRAL

☐ Crowding / spacing
☐ Overbite / deep bite
☐ Underbite / Class III
☐ Crossbite
☐ Overjet / protrusion
☐ Open bite
☐ Phase I evaluation
☐ Impacted teeth
☐ Missing teeth
☐ Habit appliance
☐ Surgical orthodontics
☐ Other

CLINICAL NOTES

ENCLOSURES & DENTAL HISTORY

PANORAMIC X-RAY ☐ None ☐ Emailed ☐ Copy given to patient

PENDING DENTAL TREATMENT BEFORE ORTHO? ☐ No ☐ Yes

DATE OF LAST DENTAL CLEANING

IF YES, DETAILS

Complimentary consultations available. We welcome your patients and value your trust in our care.

Please email the completed slip to **smile@tsaiorthodontics.ca**