



Cascade Family & Implant Dentistry

Dr. Joseph Fazzio DDS, MS Prosthodontist

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Introducing: _____ Date: _____

Phone/Email: _____

Referring Doctor: _____

Phone/Email: _____

Reason for Referral

- ☐ Removable Prosthetics
- ☐ Crown and Bridge
- ☐ Full Mouth/Extensive Rehab
- ☐ Implant Prosthetics
- ☐ Implant Surgery
- ☐ Treatment Planning/Consult

Included

- ☐ Diagnostic Casts
- ☐ CT Scan
- ☐ X-Rays

Sent Via

- ☐ Email
- ☐ Mail
- ☐ Fax
- ☐ With Patient

PLEASE INDICATE THE TOOTH/ARCH TO BE TREATED

☐ Maxilla

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

☐ Mandible

- ☐ Please contact referring doctor before proceeding with treatment

Notes: _____

Special Medical Consideration(s): _____

**ALL PATIENTS ARE RETURNED TO THE REFERRING DOCTOR
FOLLOWING COMPLETION OF TREATMENT**