Mark I. Handelsman, D.D.S. Inc.
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(310)829-7550 markhandelsmandds.com

REFERRAL SLIP

Referred by Dr._____ Today's Date_____

Patient Name _____

Teeth Numbers:

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**
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Please evaluate Patient for:

☐ Periodontal disease _____
☐ Surgical crown lengthening _____
☐ Mucogingival Recession _____
☐ Dental implant _____
☐ Extraction and site preservation _____
☐ Lesion/Biopsy _____
☐ Resorption _____
☐ CBCT _____

Notes:

1 _____

2 _____

3 _____

4 _____

5 _____