Beyond Pediatric Dentistry
8411 Preston Rd. Suite 200
Dallas, TX 75225
972-808-6825 (O)

Patient Referral Form

Patient: _____ Date of Birth: _____

Parent/Guardian: _____ Phone: _____

Reason for referral ("X" all that apply)

☐ Infant Frenectomy ☐ Child Frenuloplasty ☐ Airway Exam ☐ Dental Treatment
☐ Other: _____

Details about referral ("X" all that apply)

☐ Snoring ☐ Nursing issues ☐ Feeding issues
☐ Mouth Breathing ☐ Dental Malocclusion ☐Obstructive Sleep Apnea (enclose sleep study)
☐ Speech Problems ☐ Cranial Malformation ☐ Other: _____

Patient Has:

☐ IBCLC ☐ SLP ☐ OMT/Myofunctional Therapist ☐ ENT ☐ Sleep Physician
Other:_____

Referred by: _____ Phone: _____

Date: _____ Email: _____

☐ Will send report ☐ Would like a report back ☐ Patient will call to schedule ☐ Please call patient

Enclosed:

☐ Patient Report ☐ Sleep Study ☐ Other: _____

Please email report to: info@beyondpediatricdentistry.com
or fax to: (972)-433-6490

Thank you for your referrals.