ALFI
Oral, Dental Implant
& Facial Surgery
Texas Medical Center

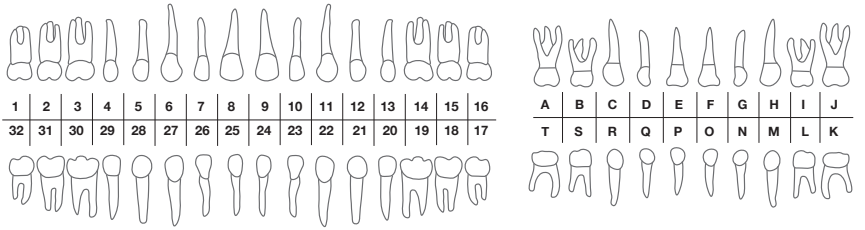
REFERRAL FORM

Patient Name: _____ Patient Phone #: _____

Referred By: _____ Date: _____

Would you like us to contact your patient? ☐ Yes ☐ No

Please circle teeth to be removed or list work to be done.



Please note third molar and implant consults/treatments require a current pano or CT scan.

☐ X-rays (date taken)_____ ☐ Emailed ☐ Taken at our office

Evaluate Treatment

☐ Extraction ☐ Expose and Bond ☐ Frenectomy ☐ Implants
☐ Bone Graft ☐ TMJ Dysfunction ☐ Apicoectomy ☐ Biopsy
☐ Orthognathic ☐ Other _____

Proposed Implant Treatment

☐ Fixed ☐ Locators ☐ Temp. Anchorage Device
☐ All-on-4® Treatment Concept

Implant System? _____

☐ Cement retained ☐ Digitally scan healing abutment
☐ Screw retained ☐ Surgical guide will be provided
☐ Digital intraoral impression/scan ☐ Flipper or replacement will be provided

Special Instructions _____

_____

_____

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