# Patient Referral

UCLA Dentistry
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## Referring Doctor Information

| | |
|---|---|
| **Name:** | |
| **Phone Number:** | |
| **Fax Number:** | |
| **Street Address:** | |
| **City, State & Zip:** | |

## Patient Information

| | |
|---|---|
| **Name:** | |
| **Date of Birth:** | |
| **Street Address:** | |
| **City, State & Zip:** | |
| **Phone Number:** | |

| | |
|---|---|
| **Tooth Number:** | |
| **Probable Restoration:** | |

## Post space needed?

- ◯ **Yes**
- ◯ **No**

## Restorability confirmed?

- ◯ **Yes**
- ◯ **No**

## Referred to which clinic?

- ◯ **Postgraduate resident clinic**
- ◯ **Faculty clinic**

## Signature Required

| | |
|---|---|
| **Date:** | |
| **Signature:** | |

**Other special instructions:**

## Internal Use Only

| Handled By: | Date |
|---|---|
| | |