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**Date:** \_\_\_\_\_

**This is to introduce:** \_\_\_\_\_

**Reason(s) for Referral:** Toothache Decay  
Special Needs Trauma Sedation/Anesthesia

**Radiographs:** Unavailable Accompanying patient  
Will be sent to your office

**Remarks:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Referred by Dr.** \_\_\_\_\_

- After completion of treatment, please have patient return to our office
- Please continue recares at your office