UNIVERSITY of WASHINGTON

Department of Orthodontics
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Referral date: _____

Please send referral form and radiographs to braces@uw.edu *

HIPAA requires using encrypted email pathways when emailing patient information.

Patient name:_____Date of birth:_____

Responsible party:_____Relationship:_____

Phone (cell): _____ Phone (work): _____

Referring doctor(s): _____

Referring phone: _____Referring email*: _____

- ☐ Comprehensive orthodontic treatment (permanent dentition)
- ☐ Limited/minor treatment
- ☐ Early orthodontic treatment (mixed dentition)
- ☐ Invisalign®
- ☐ 2nd Opinion

Chief Complaint / Area of Concern:

_____

_____

_____

Date of last cleaning _____

Type of cleaning: ☐ Prophy ☐ Perio Maintenance ☐ SRP

Is the patient periodontally stable? ☐ Yes ☐ No

Is the patient caries free? ☐ Yes ☐ No

Radiographs: ☐ FMX will be emailed* ☐ Panoramic will be emailed*

*Referral email policy