UNIVERSITY of WASHINGTON

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

Introducing: Date:

Phone (cell): Phone (work):

Referring doctor(s):

Referring phone:

- ☐ 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? ☐

Is the patient caries free? ☐

Radiographs: ☐ MX will be emailed ☐ Panoramic will be emailed

*Referral email policy