MindYourMolar

CLINIC NAME

Referral to Pedodontist (Paediatric Dentist)

Reg. No: _____ Date: _____

CHILD'S NAME

AGE / DOB

PARENT / GUARDIAN

CONTACT NUMBER

Dear **Dr.** _____,

I am referring this young patient to your paediatric dental practice for specialist evaluation and management. The child and parent have been counselled regarding the need for specialist care, and they are looking forward to meeting you.

CLINICAL FINDINGS

- Dentition stage: Primary / Mixed / Early permanent
- Chief complaint: _____
- Teeth involved: _____
- Behaviour / cooperation level: _____
- Radiographic findings: _____

REFERRAL REQUEST

→ Caries management under behaviour guidance / GA

→ Pulpectomy / pulpotomy on primary teeth

→ Space maintainer fabrication and placement

→ Early orthodontic / habit-breaking appliance

→ Dental anxiety management and behaviour modification

→ Fluoride / preventive programme for high-caries-risk child

Enclosures: ■ Case notes ■ Radiographs ■ Clinical photos ■ Lab reports

_____

Dr. _____

BDS | MindYourMolar Clinic

Reg. No: _____

CLINIC STAMP & SEAL

This referral is for specialist consultation and does not constitute a complete clinical handover. All treatment decisions remain with the receiving specialist.

MindYourMolar

CLINIC NAME

Referral to Oral & Maxillofacial Surgeon

Reg. No: _____ Date: _____

PATIENT NAME

AGE / GENDER

CONTACT NUMBER

REFERRED TO

Dear **Dr.** _____,

I am referring the above-named patient to your care for specialist surgical evaluation and management. The patient presented to my clinic with the following findings, which I believe warrant your expert assessment.

CLINICAL FINDINGS

- ♦ Chief complaint: _____
- ♦ Tooth / Region involved: _____
- ♦ Radiographic findings: _____
- ♦ Relevant medical history / medications: _____
- ♦ Provisional diagnosis: _____

REFERRAL REQUEST

- → Surgical extraction / impaction management (Tooth no: _____)
- → Biopsy and histopathological evaluation of lesion
- → Management of jaw cyst / pathology
- → Implant surgical placement
- → Pre-prosthetic surgical correction
- → Other: _____

Enclosures: ■ Case notes ■ Radiographs ■ Clinical photos ■ Lab reports

_____

Dr. _____

BDS | MindYourMolar Clinic

Reg. No: _____

CLINIC STAMP

& SEAL

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MindYourMolar

CLINIC NAME

Referral to Endodontist

Reg. No: _____ Date: _____

PATIENT NAME

AGE / GENDER

CONTACT NUMBER

REFERRED TO

Dear **Dr.** _____,

I am referring the above-named patient to your endodontic practice for specialist evaluation and management. The patient has been informed about the need for root canal treatment or related endodontic care, and consents to this referral.

CLINICAL FINDINGS

- Chief complaint: _____
- Tooth / Teeth involved: _____
- Pulp vitality test results: _____
- Radiographic findings: _____
- Provisional diagnosis: _____

REFERRAL REQUEST

→ Primary root canal treatment (Tooth no: _____)

→ Re-treatment of previously treated tooth

→ Management of calcified / obliterated canal

→ Apicectomy / periapical surgery

→ Internal / external resorption management

→ Other: _____

Enclosures: ■ Case notes ■ Radiographs ■ Clinical photos ■ Lab reports

_____

Dr. _____

BDS | MindYourMolar Clinic

Reg. No: _____

CLINIC STAMP

& SEAL

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MindYourMolar

CLINIC NAME

mindyourmolar.com

Ref No: MYM/PERIO/_____

Reg. No: _____ Date: _____

Referral to Periodontist

PATIENT NAME

AGE / GENDER

CONTACT NUMBER

REFERRED TO

Dear **Dr.** _____,

I am referring the above-named patient to your periodontal practice for specialist evaluation and management. The patient has been counselled regarding the importance of periodontal health and is aware of this referral.

CLINICAL FINDINGS

- ♦ Chief complaint: _____
- ♦ Teeth / Region involved: _____
- ♦ Probing depths / mobility grades: _____
- ♦ Radiographic bone loss pattern: _____
- ♦ Relevant medical history / medications: _____

REFERRAL REQUEST

- → Scaling and root planing / non-surgical periodontal therapy
- → Flap surgery / osseous surgery
- → Crown lengthening (functional / aesthetic)
- → Guided tissue / bone regeneration
- → Soft tissue graft / mucogingival surgery
- → Other: _____

Enclosures: ■ Case notes ■ Radiographs ■ Clinical photos ■ Lab reports

_____

Dr. _____

BDS | MindYourMolar Clinic

Reg. No: _____

CLINIC STAMP & SEAL

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MindYourMolar

CLINIC NAME

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Ref No: MYM/ORTHO/_____

Reg. No: _____ Date: _____

Referral to Orthodontist

PATIENT NAME

AGE / GENDER

CONTACT NUMBER

REFERRED TO

Dear **Dr.** _____,

I am referring the above-named patient to your orthodontic practice for specialist evaluation and management. The patient has been informed about the need for orthodontic assessment and is motivated for treatment.

CLINICAL FINDINGS

- Chief complaint: _____
- Molar relationship (R/L): _____
- Overjet / Overbite: _____
- Crowding / Spacing: _____
- Relevant habits / skeletal pattern: _____

REFERRAL REQUEST

→ Fixed orthodontic treatment (comprehensive)

→ Clear aligner therapy assessment

→ Interceptive / early orthodontic treatment

→ Space management (space maintainer / regainer)

→ Surgical orthodontic evaluation

→ Other: _____

Enclosures: ■ Case notes ■ Radiographs ■ Clinical photos ■ Lab reports

_____

Dr. _____

BDS | MindYourMolar Clinic

Reg. No: _____

CLINIC STAMP

& SEAL

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MindYourMolar

CLINIC NAME

mindyourmolar.com
Ref No: MYM/PROS/_____
Reg. No: _____ Date: _____

Referral to Prosthodontist

PATIENT NAME

AGE / GENDER

CONTACT NUMBER

REFERRED TO

Dear **Dr.** _____,

I am referring the above-named patient to your prosthodontic practice for specialist evaluation and management. The patient has been counselled regarding the need for prosthetic rehabilitation and is aware of this referral.

CLINICAL FINDINGS

- Chief complaint: _____
- Missing teeth (FDI): _____
- Existing prosthesis (if any): _____
- Occlusal assessment: _____
- Relevant medical history / medications: _____

REFERRAL REQUEST

→ Fixed prosthesis (crown / bridge)

→ Removable partial or complete denture

→ Implant-supported prosthesis planning

→ Full-mouth rehabilitation

→ Maxillofacial prosthesis

→ Other: _____

Enclosures: ■ Case notes ■ Radiographs ■ Clinical photos ■ Lab reports

_____

Dr. _____

BDS | MindYourMolar Clinic

Reg. No: _____

CLINIC STAMP & SEAL

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MindYourMolar

CLINIC NAME

mindyourmolar.com

Ref No: MYM/OM/_____

Reg. No: _____ Date: _____

Referral to Oral Medicine Specialist

PATIENT NAME

AGE / GENDER

CONTACT NUMBER

REFERRED TO

Dear **Dr.** _____,

I am referring the above-named patient to your oral medicine practice for specialist evaluation and management. The patient has been informed about the need for further investigation of their oral condition.

CLINICAL FINDINGS

- Chief complaint: _____
- Site / Distribution of lesion: _____
- Duration and progression: _____
- Associated symptoms (pain, burning, bleeding): _____
- Relevant medical history / medications: _____

REFERRAL REQUEST

→ Diagnosis and management of oral mucosal lesion

→ Biopsy and histopathological evaluation

→ Management of oral potentially malignant disorder

→ TMJ / orofacial pain evaluation

→ Salivary gland disorder management

→ Other: _____

Enclosures: ■ Case notes ■ Radiographs ■ Clinical photos ■ Lab reports

_____

Dr. _____

BDS | MindYourMolar Clinic

Reg. No: _____

CLINIC STAMP

& SEAL

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MindYourMolar

Spreading Dental Awareness. One Patient at a Time.

Referral to Gynaecologist / Obstetrician

Reg. No: _____ **Date:** _____

Patient Name: _____ **Contact Number:** _____

Age: _____ **Referred To (Dr):** _____

LMP / EDD: _____ **Trimester:** _____

Dear Dr. _____

I am referring the above-named patient, currently pregnant / lactating, for your evaluation regarding fitness for dental treatment. Kindly advise on safe timing, medication, and any precautions required before I proceed.

CLINICAL FINDINGS

- **Chief complaint** _____
- **Tooth / region involved** _____
- **Radiographic findings** _____
- **Relevant obstetric / medical history**
- **Provisional diagnosis** _____

REFERRAL REQUEST

☐ Clearance to proceed with dental treatment during current trimester
☐ Clearance for dental radiograph with abdominal shielding
☐ Clearance for local anaesthesia (with / without adrenaline)
☐ Clearance for prescribed antibiotics / analgesics (see consent box below)
☐ Other: _____

Consent for Proposed Dental Treatment & Medication

Treatment proposed	RCT	Extraction	Scaling	Restoration	Other:	
Antibiotics proposed						
Analgesics proposed						

☐ Confirmed safe for current trimester / lactation stage
☐ Dosage / drug modification advised: _____
☐ Medication contraindicated — alternative suggested: _____

Gynaecologist's advice / precautions:

Emergency protocol to follow, if any:

Gynaecologist's Signature & Stamp: _____

■ Case notes ■ Radiographs ■ Clinical photos ■ Lab reports

Dr. _____
BDS | MindYourMolar Clinic
Reg. No: _____ **Signature & Seal:** _____

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All treatment decisions remain with the receiving specialist.

MindYourMolar

Spreading Dental Awareness. One Patient at a Time.

Reg. No: _____

Date: _____

Referral to Oral Pathologist

Patient Name: _____ **Contact Number:** _____

Age / Gender: _____ **Referred To (Dr):** _____

Dear Dr. _____,

I am referring the above-named patient for evaluation of an oral lesion. The patient presented with the following findings, which I believe warrant histopathological assessment.

CLINICAL FINDINGS

- Chief complaint _____
- Site / location of lesion _____
- Duration of lesion _____
- Clinical description (size, colour, consistency, borders, surface) _____
- Radiographic findings _____
- Relevant medical history _____
- Provisional diagnosis _____

REFERRAL REQUEST

☐ Incisional biopsy
Excisional biopsy
Fine needle aspiration cytology (FNAC)
Histopathological evaluation and written report
Other:

Patient Consent for Biopsy Procedure

I consent to the proposed biopsy procedure and use of local anaesthesia
I understand a tissue specimen will be sent for laboratory analysis
I understand results may take time and further treatment will depend on the report
I understand risks may include bleeding, swelling, or infection at the site

Patient's Signature: **Date:**

Case notes **Radiographs** **Clinical photos** **Lab reports**

Dr.
BDS | MindYourMolar Clinic

Reg. No: **Signature & Seal:**

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MindYourMolar

Spreading Dental Awareness. One Patient at a Time.

REFERRAL TO PHYSICIAN / SPECIALIST

Reg. No: _____ **Date:** _____

Patient Name: _____ **Contact Number:** _____

Age / Gender: _____ **Known Medical Condition:** _____

Referral to: ☐ Nephrologist ☐ Cardiologist ☐ Gastroenterologist ☐ General Physician ☐ Other: _____

Dear Dr. _____,

I am referring the above-named patient for medical fitness evaluation prior to a planned dental procedure.
Kindly advise on suitability of the proposed medications given the patient's medical status.

CLINICAL FINDINGS

- **Chief complaint** _____
- **Tooth / region involved** _____
- **Radiographic findings** _____
- **Relevant medical history / current medications** _____
- **Recent investigations (e.g. creatinine / eGFGR, INR, HbA1c)** _____
- **Provision diagnosis** _____

PROPOSED TREATMENT PLAN

☐ Root Canal Treatment (RCT) ☐ Extraction (Tooth no: _____) ☐ Other: _____

MEDICATION PLAN & PHYSICIAN CONSENT

Antibiotics proposed : _____

Analgesics proposed : _____

Other medication proposed : _____

☐ I confirm the above medications are safe for this patient given their medical condition

☐ Dosage / drug modification advised: _____

☐ Medication contraindicated, alternative suggested: _____

Physician's advice / precautions before proceeding:

Emergency protocol to follow, if any:

Physician's Signature & Stamp: _____

■ Case notes ■ Radiographs ■ Clinical photos ■ Lab reports

Dr. _____
BDS | MindYourMolar Clinic

Reg. No: _____ **Signature & Seal:** _____

This refers to specialist consultation and does not constitute complete handover.
All treatment decisions remain with the receiving specialist.