Bellevue Dentist
Smiles by Siamak Najafi, DDS

Prosthodontic Referral Form

Patient's Name: _____ DOB: _____

Patient's Contact Info: _____ Date: _____

Referring Doctor: _____ Dr's Office Phone: _____

Reason for Referral:

- ☐ Comprehensive Prosthodontic Evaluation
- ☐ This patient is referred to your office for implant placements ONLY, please refer the patient back for restoration along with the implant information.
- ☐ Other: _____

The referring office will send diagnostic information below:

- ☐ Radiographs
- ☐ Intraoral scan (.stl/.ply)
- ☐ Models
- ☐ CBCT scan (.dicom)
- ☐ Clinical Pictures
- ☐ Periodontal Charting

Thank you for your referral. We will get back to you with the prosthodontic evaluation progress.

Additional Comments:

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Address: 14645 Bel-Red Rd, Suite 100, Bellevue, WA 98007
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