CLE
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PATIENT'S NAME _____

REFERRED BY _____

DATE REFERRED _____

PLEASE INDICATE TREATMENT OR CONSULTATION DESIRED:

UPPER

1 2 3 4 5 6 7 8	9 10 11 12 13 14 15 16
A B C D E	F G H I J
R ———	——— L
T S R Q P	O N M L K
32 31 30 29 28 27 26 25	24 23 22 21 20 19 18 17

LOWER

- ☐ CONSULTATION
- ☐ EXTRACTION - ROUTINE
- ☐ EXTRACTION - SURGICAL
- ☐ PANOREX - TMJ XRAY
- ☐ IMPACTION
- ☐ LOCAL ANESTHESIA
- ☐ INHALATION ANESTHESIA
- ☐ INTRAVENOUS ANESTHESIA
- ☐ BIOPSY
- ☐ ALVEOPLASTY
- ☐ APICOECTOMY & ROOT CANAL OR RETROGRADE
- ☐ ENUCLEATION OF CYST
- ☐ TUBEROSITY REDUCTION
- ☐ REMOVAL OF HYPERTROPHIED TISSUE
- ☐ NERVE REPAIR (MICROSCOPIC)
- ☐ LASER SURGERY
- ☐ VESTIBULE EXTENSION & TISSUE GRAFT
- ☐ REMOVAL OF TORUS
- ☐ IMMEDIATE DENTURE PLACEMENT
- ☐ FRENECTOMY - FRENOPLASTY
- ☐ INCISION DRAINAGE
- ☐ EXPOSURE OF UNERUPTED TOOTH
- ☐ SINUS REPAIR
- ☐ DENTAL IMPLANT
- ☐ SUBPERIOSTEAL IMPLANT
- ☐ FACIAL FRACTURE REPAIR
- ☐ MAXILLARY OSTEOTOMY
- ☐ MANDIBULAR OSTEOTOMY
- ☐ GENIOPLASTY
- ☐ FACIAL PAIN EVALUATION
- ☐ TMJ EVALUATION - SURGERY
- ☐ OTHER

COMMENTS: _____

TOP COPY – REFERRING DOCTORS FILE BOTTOM COPY – PATIENT COPY