Chester Dental Care

Airway-Centered Dentistry

Shwetha Rodrigues, DDS

12517 Route 1, Chester, VA 23831 · 804-748-2555 · frontdesk@chesterdentalcareva.com

Patient Referral Form

PATIENT INFORMATION

PATIENT NAME

DATE OF BIRTH

PARENT / GUARDIAN (IF MINOR)

PHONE

EMAIL

REFERRING PROVIDER

PROVIDER / PRACTICE

SPECIALTY

PHONE

EMAIL

PREFERRED CONTACT

REASON FOR REFERRAL — CHECK ALL THAT APPLY

- ☐ Mouth breathing
- ☐ Snoring / sleep-disordered breathing
- ☐ Poor sleep / restless sleep
- ☐ Bed wetting / enuresis
- ☐ ADD / ADHD / attention concerns
- ☐ Narrow palate / crowding
- ☐ Tight / restricted frenum
- ☐ Tongue posture / swallow concerns
- ☐ Oral habits / open-mouth posture
- ☐ TMJ / clenching / grinding
- ☐ Crossbite / underbite / bite concerns
- ☐ Headaches / facial or jaw discomfort
- ☐ Other concern

REQUESTED EVALUATION / COLLABORATION

- ☐ Comprehensive airway-centered evaluation
- ☐ Pediatric growth & development evaluation
- ☐ Adult airway rehabilitation evaluation
- ☐ Myofunctional evaluation / therapy
- ☐ TMJ / functional evaluation
- ☐ CBCT / craniofacial-airway assessment
- ☐ Appliance / orthopedic evaluation
- ☐ Collaborative consultation / second opinion

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RELEVANT HISTORY & RECORDS — CHECK ALL THAT APPLY

- ☐ Sleep study / OSA diagnosis
- ☐ CPAP / oral sleep appliance
- ☐ Photos
- ☐ ENT / tonsil-adenoid history
- ☐ Panoramic radiograph
- ☐ Orthodontic history
- ☐ CBCT
- ☐ Other _____

CLINICAL NOTES / SPECIFIC QUESTIONS

Thank you for entrusting us with your patient.

Shwetha Rodrigues, DDS