



Highlands Dentistry | Ray Besharati, DDS, DMD
2520 NE Park Dr., Suite C | Issaquah, WA 98029

PATIENT REFERRAL

Date: _____

Total pages: _____

Phone: (425) 996-0457

FAX TO: (425) 996-0472

Please fax completed form and records.

1 PATIENT INFORMATION

Patient name: _____ DOB: _____

Phone: _____ Alternate phone: _____

Parent/guardian (if applicable): _____

2 REFERRING PROVIDER

Provider name: _____ Specialty: _____

Practice: _____

Phone: _____ Return fax: _____

3 REFERRAL REQUEST | Check all that apply

- | | | |
|--|---|--|
| ☐ TMJ / facial pain | ☐ Sleep apnea / oral appliance | ☐ General dentistry |
| ☐ Consultation | ☐ Evaluation and treatment | ☐ Second opinion |

Reason for referral / diagnosis / specific question:

Relevant history, previous treatment, and response:

4 RECORDS ENCLOSED | If available and relevant

- | | | |
|---|--|--|
| ☐ Clinical notes | ☐ Imaging / reports | ☐ Medication / allergy list |
| ☐ Sleep study report | ☐ Sleep physician notes | ☐ Insurance information |

5 SCHEDULING & PROVIDER SIGNATURE

- | | |
|---|--|
| ☐ Please contact patient to schedule | ☐ Patient will call to schedule |
|---|--|

Provider signature: _____ Date: _____

raybesharati.com | Mon-Thu, 7:00 AM-4:00 PM | Time-sensitive referral? Please call.

Confidential patient information. This form is not monitored for emergencies.