

This form is to refer: \_\_\_\_\_ Date: \_\_\_\_\_

To: Elizabeth Malette Barber DDS MS, Pediatric Dentist

**Referring Professional:**

Name \_\_\_\_\_

Phone \_\_\_\_\_

**Date of Service Rendered:**

Oral Prophylaxis \_\_\_\_\_ BW Radiograph \_\_\_\_\_

Topical Fluoride \_\_\_\_\_ PA Radiograph \_\_\_\_\_

**Comments/Concerns:**

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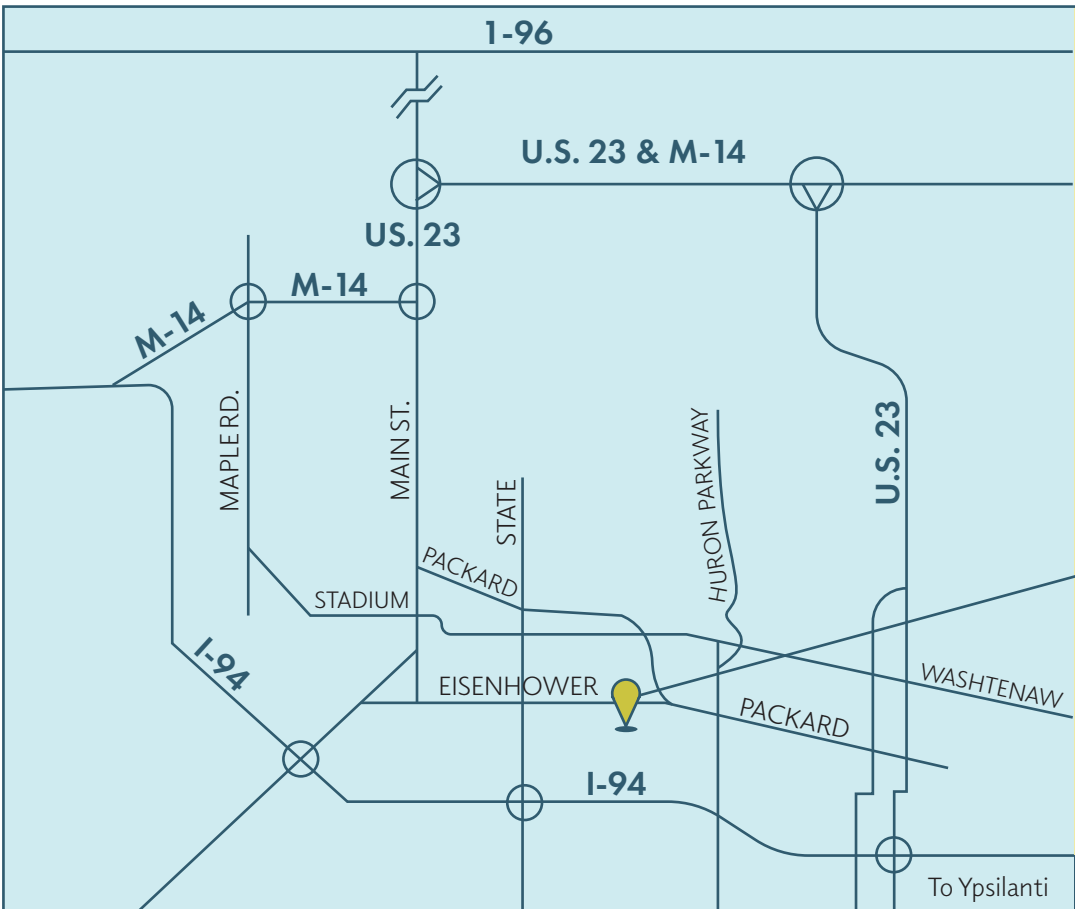
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**BLOSSOM**  
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& Orthodontics

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