



CUSP UNTETHERED

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Date: _____

Introducing my patient: _____

DOB: _____ Phone: _____

Referred by: _____

Cotreatment team: _____

Reason for referral:

- Frenectomy **Consult Only**
 - Lingual
 - Labial (Upper / Lower)
 - Buccal

- Frenectomy Consult and Treatment
 - Lingual
 - Labial (Upper / Lower)
 - Buccal

- Solea Sleep Consult/Treatment

- Botox / Xeomin Consult/Treatment

Remarks / Concerns:

Signature: _____