



Robin E. Bagby, DDS  
Michael J. Mayerchak, DMD

Today's Date \_\_\_\_\_

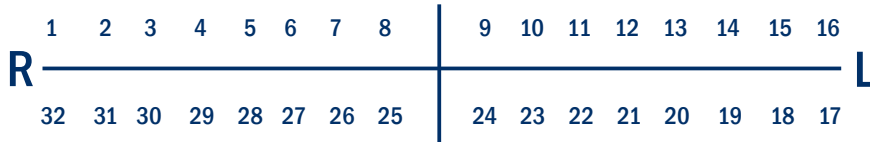
This is to introduce \_\_\_\_\_  
FIRST NAME LAST NAME (patient daytime phone #)

Patient scheduled for an appointment in your office \_\_\_\_\_  
at \_\_\_\_\_  am  pm

**Doctor's Recommendation for Referral**

- Endodontic Treatment
- Consultation and Diagnosis (treat as needed)
- Microsurgery/Apicoectomy
- Emergency Treatment
- Retreatment
- CBCT Imaging/Evaluation
- Conscious Sedation
- Consultation Only

Please Circle Tooth or Teeth Number



Prepare Post Room  Yes  No

Restorative, Periodontal Treatment and /or Temporary Filling Preference. Comments:

Referred by Dr. \_\_\_\_\_

Please Call me at \_\_\_\_\_

Please email or fax this referral form to us:

email doctors@blueridgeendo.com fax (540) 772-0716

Please also give the patient a copy to bring for their appointment.

We will verify all insurance plans for your patients.

We are committed to professional and compassionate care.

**Main Office**  
4102 Electric Road  
Roanoke, VA 24018

**Satellite Office**  
104 S. Jefferson Street  
Lexington, VA 24450

(540) 772-9515 blueridgeendo.com