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Certified Specialist in Paediatric Dentistry

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REFERRAL

Patient Information

Name: _____ ☐ M ☐ F Birth Date: _____

Address: _____ Postal Code: _____

Parent(s)/Guardian: _____

Phone: Res: _____ Bus: _____ Cell: _____

Consultation is requested for: (check all that apply)

☐ caries ☐ infection ☐ trauma ☐ pathology ☐ management

☐ other _____

Medical History

☐ healthy ☐ _____

Insurance

☐ private ☐ none

Records

☐ bitewings ☐ periapicals ☐ panoramic ☐ photos ☐ Date: _____

☐ mailed/courier ☐ emailed ☐ coming with patient ☐ digital images ☐ no records

When treatment is complete, how would you like us to manage this patient?

☐ refer back to your office ☐ keep patient here until older ☐ parent to decide

Referring Doctor

Name: _____

Office Location (if more than one): _____

Office Phone: _____

Email: _____

Date: _____

Thank you for your referral