Patient Referral Form

RESTORATIVE DENTISTRY AND PROSTHODONTICS
BURLINGTON
DR. PEDLAR

Referring Practitioner:

Name: _____

Address: _____

City: _____

Province: _____ Postal Code: _____

Telephone: _____

Fax: _____

Email: _____

Patient Information:

Patient Name: _____

Date of Birth: (M/D/Y) _____

Address: _____

City: _____

Province: _____ Postal Code: _____

Telephone – Home: _____

Telephone – Work: _____

Telephone – Mobile: _____

Reason for Referral:

◯ Cosmetic Dentistry/Restorative Dentistry ◯ Large Rehabilitation ◯ Dentures / Implants

◯ Implants Only ◯ Implants and Final Restoration ◯ Restorative TMJ

Follow-Up Information:

◯ Please call the patient ◯ Patient will call ◯ An appointment has been made

◯ Please report – written ◯ Please report – by phone ◯ Radiographs are enroute

◯ Please return radiographs after use ◯ Notify on completion ◯ Other records are available

Post-Referral Maintenance:

◯ By Specialist ◯ In this office ◯To be discussed

Case Details:

◯ Investigate and Treat ◯ For Opinion Only

Chief Complaint:

_____

_____

_____

Additional Details / Requests:

_____

_____

_____

Relevant Medical History:

_____

_____

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