STANDARD DENTAL REFERRAL FORM

APPROVED BY THE CANADIAN DENTAL ASSOCIATION

FROM: ______________________________

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TO: Nancy Kennedy Dentistry

101-190 Victoria Road, Dartmouth NS B3A 1W2

telephone: 902-464-4444

fax: 902-464-4499

We are referring:

Patient: ______________________________

Birthdate: ______________________________ (M / D / Y)

Address: ______________________________

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Telephone: ______________________________

Parent/Guardian: ______________________________

Telephone: ______________________________

REASON FOR REFERRAL:

❑ **CONSULTATION RE:** ______________________________

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❑ **TREATMENT (as requested):**

(Please provide specialist with appropriate details of problem; i.e. urgency, areas of concern, using F.D.I. tooth numbering system.)

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RELEVANT HISTORY:

(Indicate any special factors – either dental or medical – such as known allergies and specific medical problems relevant to diagnosis and treatment.)

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❑ **Please call the patient.**

❑ **Patient will call.**

❑ **An appointment has been made.**

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❑ **Radiographs are enclosed.**

❑ **Please return radiographs after use.**

❑ **Notify on completion.**

❑ **Please report – written**

❑ **Please report – by phone**

❑ **Post-referral maintenance** ❑ ***By specialist***

❑ ***In this office***

❑ ***To be discussed***

❑ **Other records are available.**

SIGNED: ______________________________ **DATE:** ______________________________