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****All fields MUST be completed and MUST BE SIGNED by the referring DDS/MD****

Referring DDS or MD (&Ref #**):** _____

Address: _____

Phone#: _____ **Fax#:** _____

Email: _____ **Contact Person:** _____

* * * * * * * *

Patient's Legal Name: _____

Address: _____

D.O.B: _____ **Health Card # & VC:** _____

Contact Person & Relationship: _____

Phone #: _____ **E-mail:** _____

Reason for Consult: _____

_____

X-Rays: ☐ No ☐ Yes & Type: _____ **E-mailed?** ☐ Yes ☐ No

Medical Concerns: _____

_____

Insurance: □ None □ Private □ Government & Type: _____

Additional Information: _____

DDS/MD's Signature: _____