

PATIENT INFORMATION

Name: _____

Phone: _____

Email: _____

Date of Birth: _____

REFERRING DENTIST / PRACTICE INFORMATION

Name: _____

Phone: _____

Email: _____

Fax: _____

REASON FOR REFERRAL

Restorative and General (with sedation)

- ☐ Restorative Treatment with Sedation
(Please specify tentative treatment plan)
- ☐ Root Canal Therapy with Sedation
- ☐ Dental Hygiene with Sedation
- ☐ Implant Restorations

Oral Surgery

- ☐ Extractions
- ☐ Wisdom Teeth Extractions
- ☐ Pre-Prosthetic Surgery
- ☐ Periodontal Surgery (CTG or FGG)

Dental Implant / Surgical

- ☐ Single/Multiple Tooth Implant Placement
- ☐ Immediate Placement with Temporization
- ☐ Extractions with Socket Preservation
- ☐ Guided Tissue Regeneration

Other

- ☐ Sleep Apnea Testing
- ☐ Other: _____

RADIOGRAPHS

- ☐ Brightsquid Secure-Mail
- ☐ CDA Secure Send
- ☐ Mailed
- ☐ With Patient
- ☐ Please Obtain
- ☐ Enclosed

TENTATIVE TREATMENT PLAN

- ☐ Brightsquid Secure-Mail
- ☐ CDA Secure Send
- ☐ Mailed
- ☐ Enclosed

PATIENT RETURN (At what stage would you like your patient returned to you)

- ☐ After treatment with sedation is complete
- ☐ After surgery only
- ☐ After surgical placement of implant only
- ☐ After required implant supported/fixed or removable prosthesis/restoration
- ☐ Other: _____

Please send radiographs and records by **Brightsquid Secure-Mail** or **CDA Secure Send** to info@midtowndentalcalgary.com, or fax this form to **403-228-9185**. We contact your patient within 2 business days.