

Patient Referral Form

Thank you for trusting us with your patient's care. Please complete this form and send it along with any relevant records.



REFERRING DENTIST / CLINIC INFORMATION

First Name: _____ Last Name: _____ Phone: _____
Office Name: _____ Office Location: _____
Submitted By: _____ Preferred Email: _____



PATIENT INFORMATION

Name: _____
DOB: _____
Home Address: _____



PARENT / GUARDIAN INFORMATION

Name: _____
Relation: _____
Phone: _____ Email: _____



PATIENT MEDICAL CONCERNS



DENTAL REFERRAL DETAILS

Reason for Referral

Previous Treatment (radiographs, fillings, crowns, nerve therapy, etc. +/- behavioural concerns)

Expected Treatment Needs

Dental Coverage: _____



PRIORITY

- ☐ Whenever Possible ☐ Urgent
☐ Emergency (must be seen immediately)

Details: _____



RADIOGRAPHS

- ☐ Uploaded / emailed ☐ Taken and given to parent/guardian
☐ Will forward via mail/courier ☐ Not available – did not attempt
☐ Not available – not indicated

Date Taken: _____



IN THE FUTURE

Once treatment is complete, we should:

- ☐ Refer patient back following the consultation ☐ Refer patient back following the completion of treatment ☐ Keep patient with us until the child is older



ADDITIONAL INFO
