

Patient Referral Form

Date _____

Full Name _____

Date of Birth _____ Phone _____

Parent/Guardian _____

Appointment Information: ☐ Patient will call ☐ Please contact patient

Referred By: Practice _____ Doctor _____

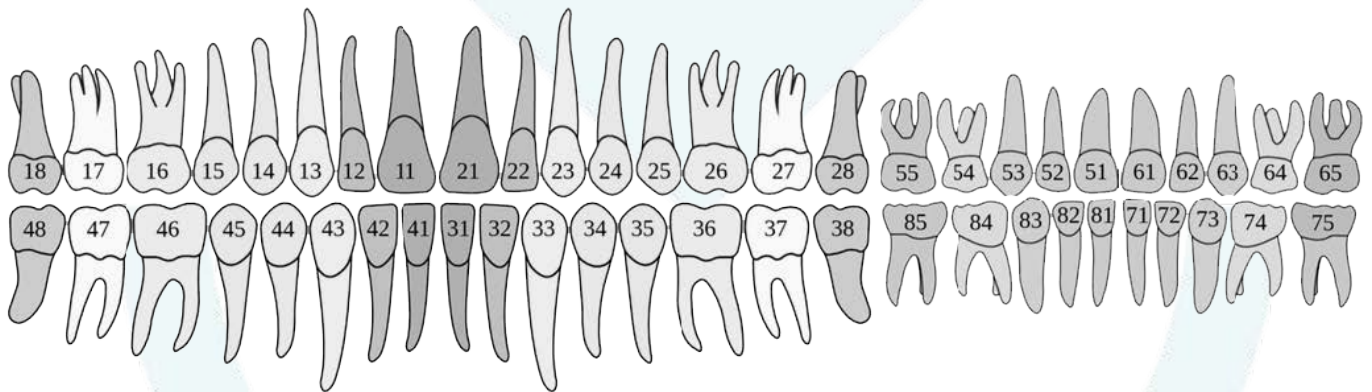
Phone _____ Email _____

Reason for Referral

General Dentistry: ☐ Pediatrics ☐ Adult ☐ Seniors

Special Care Dentistry: ☐ Pediatrics ☐ Adult ☐ Seniors ☐ Wheelchair

Sedation: ☐ Sleep Dentistry - General Anesthesia ☐ Nitrous Oxide



Radiographs and Clinical Information

☐ Sent with patient ☐ Sent by email ☐ Sent by mail ☐ Take new radiographs

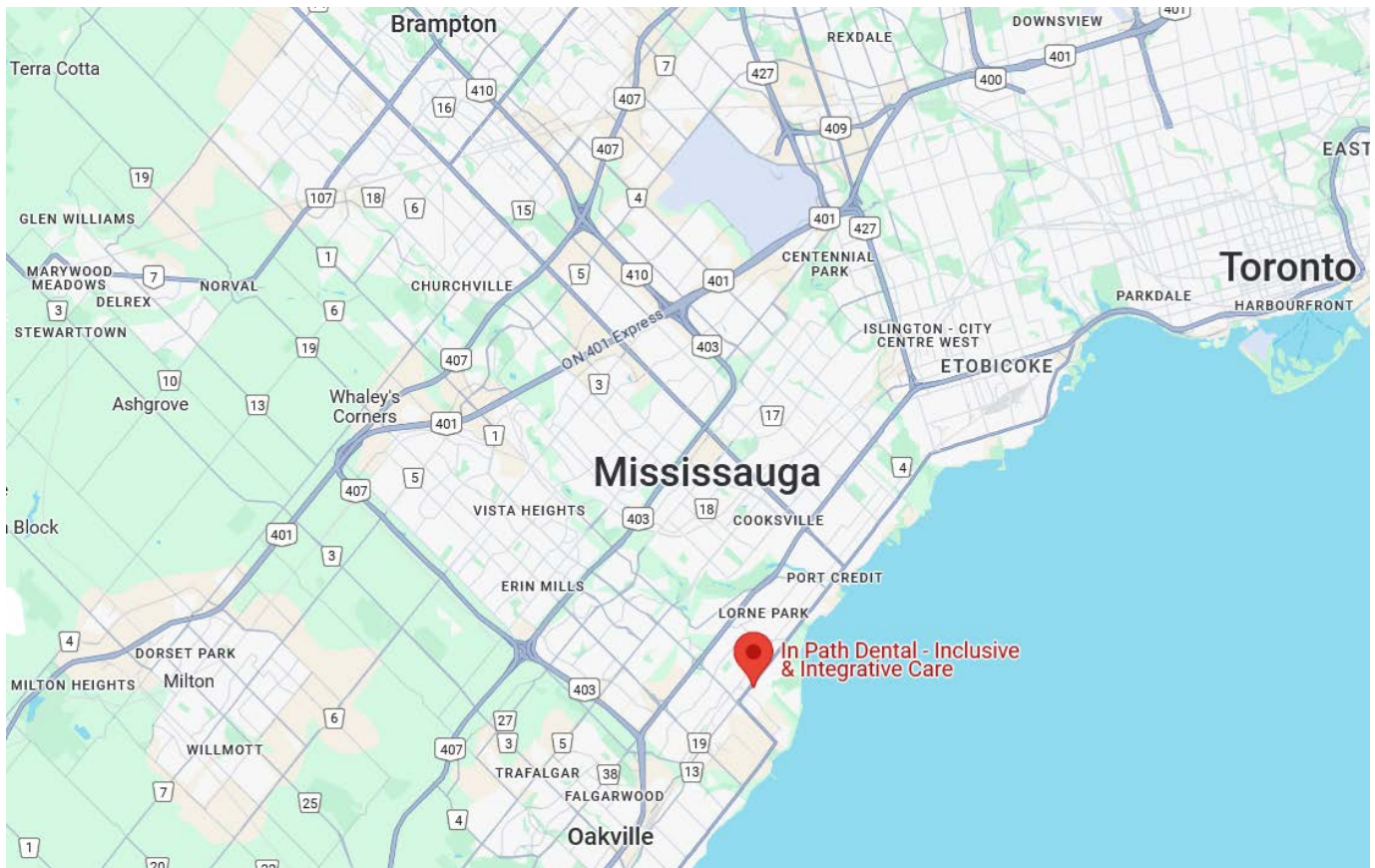
Notes _____

Our Facility

Our one-of-a-kind clinic features an accessible and sensory calming infrastructure. This creates a safe atmosphere for patients that is second to none in all of Canada. Fully equipped with a dedicated surgical operatory and a complete recovery room.

**Please reach out to
our office to learn more
about working with us.**

(905) 855-9111



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