STANDARD DENTAL REFERRAL FORM
APPROVED BY THE CANADIAN DENTAL ASSOCIATION

FROM: _______________________________ TO: _______________________________

We are referring:

Patient: _______________________________ Parent/Guardian: _______________________________
Birthdate: ____________________ (M / D / Y) Telephone: _______________________________
Address: ____________________________________________ Telephone: _______________________________

REASON FOR REFERRAL:

☐ CONSULTATION RE: _______________________________

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

RELEVANT HISTORY:

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

☐ Please call the patient. ☐ Please report – written
☐ Patient will call. ☐ Please report – by phone
☐ An appointment has been made. ☐ Post-referral maintenance ☐ By specialist
☐ Radiographs are enclosed. ☐ In this office
☐ Please return radiographs after use. ☐ To be discussed
☐ Notify on completion. ☐ Other records are available.

SIGNED: _______________________________ DATE: _______________________________