Kids Dental Referral Form

128-2025 Corydon Ave, Tuxedo Park Shopping Centre
Winnipeg, MB R3P 0N5 P: 204.222.5437 F: 204.489.1785

From:	**To:**

PATIENT INFORMATION

Name:	**D.O.B.:**	**Parent/Guardian:**	**Phone:**

Address:

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

Signed:	**Date:**