



CANADIAN
DENTAL
ASSOCIATION

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.
- Patient will call.
- An appointment has been made.

- 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: _____