



All questions contained in this questionnaire are strictly confidential and will become par of your medical record

Patients Details

Referring Dentist:

Name *(Last, First, M.I.)*

Name *(Last, First)*

Phone Number:

Phone Number:

Email:

Email:

D.O.B:

Referral For:

- General Anesthesia** **IV Sedation**
 Implants **Other**

Treatment Plan Included: Yes No

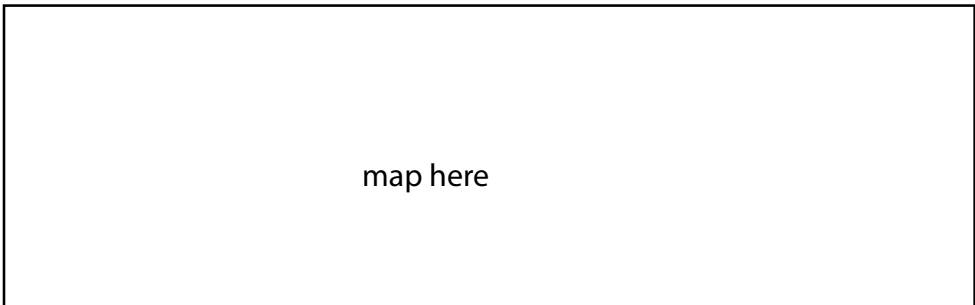
Notes:

Reason For Referral:

- Anxiety** **Extensive Treatment Required**
 Co-operation

Relevant Radiographs:

- Mailed** **Sent with patient**
 Emailed **Please note**



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