GEORGIAN MALL
DENTAL GROUP™

LIVBRITE

Orthodontist | Pediatric | Oral Surgeon | Endodontist | Periodontist | Prosthodontist

Patient Referral Form

Referring Doctor Information

Name of Referring Doctor _____ Phone # _____

Email Address _____ Date of Referral ____/____/____
MM DD YYYY

Patient Information

First Name _____ Last Name _____

Mobile Phone # _____ Work Phone # _____

Date of Birth ____/____/____ Email _____
MM DD YYYY

Radiographs ◯ Mailed ◯ Emailed ◯ Given to Patient ◯ Please take

Pediatrics

- ◯ Comprehensive treatment
- ◯ Specific treatment
- ◯ Emergency treatment
- ◯ Sedation
- ◯ Other

Periodontics

- ◯ Gingival recession
- ◯ Crown lengthening
- ◯ Bone grafting
- ◯ Sinus augmentation
- ◯ Implant
- ◯ Other

Oral Surgery

- ◯ Extraction _____
- ◯ Implants _____
- ◯ Pathology _____
- ◯ Trauma _____
- ◯ TMJ _____
- ◯ Other _____

Endodontics

- ◯ Consultation
- ◯ Patient has discomfort
- ◯ Endo initial treatment
- ◯ Endo retreatment
- ◯ Apical surgery
- ◯ Other

Orthodontics

- ◯ Comprehensive treatment
- ◯ Limited treatment
- ◯ Checkup
- ◯ Other

Prosthodontics

- ◯ Full mouth rehabilitation
- ◯ Consultation and treatment
- ◯ Implant pre-surgical planning
- ◯ All-On-Four planning and restoration
- ◯ Other

Sedation ◯ Please discuss with patient

Cone Beam Computed Tomography

A. TMJ (please check all that apply)
◯ Close ◯ Open ◯ Bite registration

B. Pathologic investigations
◯ Intra-osseous ◯ Soft tissue ◯ Temporomandibular joints

C. Implants
◯ Stent provided ◯ Measurements ◯ Pathology check only

D. Endodontics
◯ Root fracture ◯ Apical pathoses ◯ Perforation ◯ Canal anatomy

Special instructions _____

TEL - 705-252-7772 **FAX** - 705-252-0779 **EMAIL** - info@georgianmalldentalgroup.com
509 Bayfield St., N47A, Barrie, ON L4M 4Z8
GeorgianMallDentalGroup.com