



ORAL SURGERY REFERRAL FORM - Please complete the following referral information

Grid of checkboxes for referring physicians: Dr. Brian Rittenberg, Dr. Eric Ebrahimi, Dr. Geoffrey Duviner, Dr. Marco Caminiti, Dr. Kristopher Lee, Dr. Howard Holmes, Dr. Joel Davis, Dr. Karl Cuddy, Dr. Justin Garbedian.

REFERRAL INFORMATION

Referral Date: YYYY / MM / DD Referral Name:

Referral Address (full address required) Tel # Fax :

PATIENT INFORMATION

Patient's Name: Date of Birth: (YYYY / MM / DD) Gender: Address: Postal Code: Please check off preferred contact (Tel: Home, Work, Cell) Health Card Number (OHIP #) Version Code:

INFORMATION MUST BE COMPLETED IN FULL - PRINT CLEARLY

Urgency of care: [] Urgent [] Routine
RADIOGRAPHS: [] Please take [] With Patient [] Mailed [] Photos [] Panorex [] Ceph Radiograph [] CBCT
Digital xrays (Printed NOT accepted) [] Patient to bring [] Email (call the office for instructions)

Reason for Referral: [] Extraction [] Implants: Specify area [] Pathology: Specify area [] Orthognathic Surgery: Skeletal Diagnosis [] Trauma [] Bone Grafting Other:

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Relevant Medical History:

Current Medications:

Please:

- Fax this referral form to the practice listed above
Call the office for email information regarding the transfer images
Please inform our office if an interpreter is required.
Cancellation Policy: This appointment time is reserved for your patient. If unable to attend, our office must be notified at least 3 working days in advance to avoid cancellation charges.