KOOTENAY LAKE
DENTAL

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PATIENT NAME		EMAIL	
DATE OF BIRTH		PHONE	
PERSONAL HEALTH NUMBER		ADDRESS	
PARENT / GUARDIAN (if minor)			

Thank you for referring your patient to us!

Reason for referral :

- ☐ General anesthesia
- ☐ Specific treatment
- ☐ Comprehensive care

TEETH/AREA

_____
_____
_____
_____
_____
_____

- ☐ Behaviour/age
- ☐ Medically compromised/special needs

COMMENTS

_____
_____
_____
_____

RADIOGRAPHS

☐ None available ☐ Enclosed

- ☐ Please call this family to arrange a consultation.
- ☐ This family will call your office to arrange a consultation.

REFERRING PRACTITIONER

Name _____

Phone Number _____

Date _____