DOCS
DENTISTRY ON CATHERINE STREET

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inquiries@docsottawa.com

Patient Information

Prefix _____ First Name _____ Last Name _____ DOB (DD/MM/YYYY) _____

Address _____

City _____ Province _____ Postal Code _____ Phone (Home) _____ Phone (Cell) _____

Email Address _____

Administrative Information

Referring Dentist _____ Ref. Office Name _____ Ref. Office Phone _____

Ref. Office Email Address _____ Date Referred (DD/MM/YYYY) _____

Preferred Method of Communication: ☐ CDA SecureSend ☐ Mail ☐ Fax

Treatment Information

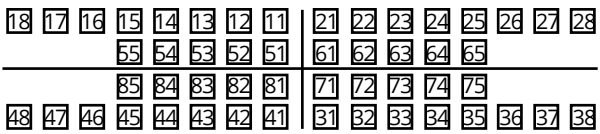
Patient has had recent radiographs:

☐ Yes - Date: _____

☐ No

If yes, please send via mail or CDA SecureSend

Please mark teeth or area to be treated



Periodontics

☐ **First Available** ☐ Karen Fung ☐ Janelle Hamilton

☐ Eugenie MacKay ☐ Alison McGuire ☐ Jacob Fitzgerald

Reason for referral:

☐ Specific Consultation ☐ Comprehensive Consultation

☐ Soft-Tissue Grafting ☐ Extraction(s) ☐ Implant(s) ☐ Biopsy ☐ Other: _____

Oral Surgery

☐ **First Available** ☐ Brent Johnson ☐ Ahmed Almuzayyen

Reason for referral:

☐ 3rd Molar Extractions ☐ Extraction(s) ☐ Implant(s) ☐ Biopsy ☐ Other: _____

Endodontics

☐ **First Available** ☐ Lyon Hamburg ☐ Michael Rapp

Reason for referral:

☐ Consultation ☐ Root Canal Therapy ☐ Periapical Surgery

Additional diagnostic information:

☐ Sensitivity to Cold/Hot ☐ Retreatment ☐ Post Space Required

☐ Severe Pain/Swelling ☐ Elective Endodontics ☐ IV Sedation Required

☐ Pain to biting and/or pressure sensitivity ☐ Non-specific pain for diagnosis ☐ Antibiotic Premedication Required

Sleep Apnea and TMD

☐ Sherif Elsaraj

Reason for referral:

☐ TMD Assessment ☐ Sleep Apnea Assessment ☐ Other: _____

Additional Notes

_____

_____

Thank you for your referral!