FUNDY DENTAL CENTRE

7322 Highway 1
Coldbrook, NS B4R 1B9
902-681-9111

REFERRAL FORM

Please fill out form completely, and submit form in PDF format. Image files be labeled with pt's name/date, & sent in image format.

Referring Dentist Info:

Dentist: _____
Office: _____
Phone: (_____) _____ - _____
Email: _____

Date of Referral (DD-MM-YEAR): _____ -_____ -_____

Referral To:

- ☐ First Available Dentist
- ☐ Specific Dentist: _____
- ☐ Pedodontist

PATIENT INFORMATION

☐ ***FDC Internal Referral – see pt's chart***

Name: _____ Birth Date (DD-MM-YEAR): _____ -_____ -_____

Address: _____ Health Card # _____

Town: _____ Prov: _____ Postal Code: _____

Home Ph: (_____)_____ Cell Ph: (_____)_____

DENTAL COVERAGE

- Dental Coverage under government assistance? *(circle)* Social Assistance | Disability | MSI | NIHB | VA | CDCP
- Dental Insurance? Yes | No Secondary Ins.: Yes | No *(Our office will confirm details with the patient.)*

MEDICAL HISTORY

- Conditions: _____
- Medications: _____
- Allergies: _____

Height: _____
Weight: _____
BMI = _____

IMAGES

Attached: ☐ CBCT ☐ PAN ☐ PA(s) ☐ BW(s) ☐ PHOTO(s) **Taken** (DD-MM-YEAR): _____-_____-_____

Sent by: ☐ Hard Copy ☐ Emailed ☐ Uploaded to DS Core ☐ **No images to send.**

REASON FOR REFERRAL

- ☐ Emergency *(ASAP)*
- ☐ Consultation
- ☐ Sedation: IV | Oral | N2O2
- ☐ Extraction
- ☐ Restorative/Endo
- ☐ Implant
- ☐ Pedodontist
- ☐ CBCT **(** + / - Report **)**
- ☐ Other: _____

Treatment Plan & Additional Notes:

[OFFICE USE ONLY]

☐ Tx approved w/ Dentist ☐ Patient File Created ☐ Ref Imported ☐ X-rays Imported

Attempted Contact: (1st) _____ (2nd) _____ **BOOKED:** _____, _____