

Maple Place

DENTAL CENTRE

#106 - 22971 Dewdney Trunk Rd., Maple Ridge, BC V2X 3K8
Tel: 604-466-2933

We are Referring

Patient: _____ DOB: _____
Address: _____
City: _____ Postal Code: _____
Home Phone: _____ Bus/Cell: _____
Ins. Comp: _____ Group #: _____ ID #: _____
Policy Holder: _____ DOB: _____

Reason for Referral

- | | |
|--|---|
| <input type="checkbox"/> Consult | <input type="checkbox"/> Treatment (consult has been completed) |
| <input type="checkbox"/> Oral Sedation | <input type="checkbox"/> IV Sedation |
| <input type="checkbox"/> Grafting | <input type="checkbox"/> Invisalign |
| <input type="checkbox"/> Adult | <input type="checkbox"/> Removal of remaining 3rd molars |
| <input type="checkbox"/> Other Extractions | <input type="checkbox"/> Biopsy or Management of Cyst/Tumor |
| <input type="checkbox"/> TMJ non surgical only | <input type="checkbox"/> Implants single tooth replacement |
| <input type="checkbox"/> Implants for Bridge | <input type="checkbox"/> Implants for Dentures |

Please indicate below which teeth require attention

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38

- | | | |
|---------------------|--|--|
| Radiographs: | <input type="checkbox"/> Mailed or Emailed | <input type="checkbox"/> Not Available |
| Medical History: | <input type="checkbox"/> Mailed or Emailed | <input type="checkbox"/> Not Available |
| Treatment Estimate: | <input type="checkbox"/> Mailed or Emailed | <input type="checkbox"/> Not Available |

(If consult has been completed)

Comments: _____

Referred by

Dr.: _____
Address: _____
Phone: _____ Date: _____