Tooth Fairy Kids
Pediatric Dentistry

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Certified Specialist in Pediatric Dentistry

Date: / /

Patient Referral Form

Patient Information

Patient's Name (Required)

First | Middle | Last

Gender (Required)

- ○ Male
- ○ Female
- ○ Other

Legal Guardian's Name

Patient's Date of Birth

Mailing Address

Street Address

Province | City | Postal Code | Phone (Required)

Referring Doctor Information

Name / Office (Required) | Date of Referral | Phone (Required) | Email (Required)

Reasons for Referral (Required)

- ☐ Anxiety
- ☐ Pain
- ☐ Sedation
- ☐ Medical Concern
- ☐ Restorative Work Required
- ☐ Previous Negative Experience
- ☐ Specific Concern
- ☐ Other

Please check off all that applies

- ☐ Provide treatment for all dental issues found
- ☐ Call to discuss referral
- ☐ Treat patient and refer-back
- ☐ Treat patient and continue to see until adulthood

Radiographs

Does the patient have radiographs? (Required)

○ Yes ○ None

Date of radiographs

Type of Radiographs

- ☐ Bitewings
- ☐ Panoramic
- ☐ Periapical
- ☐ Other

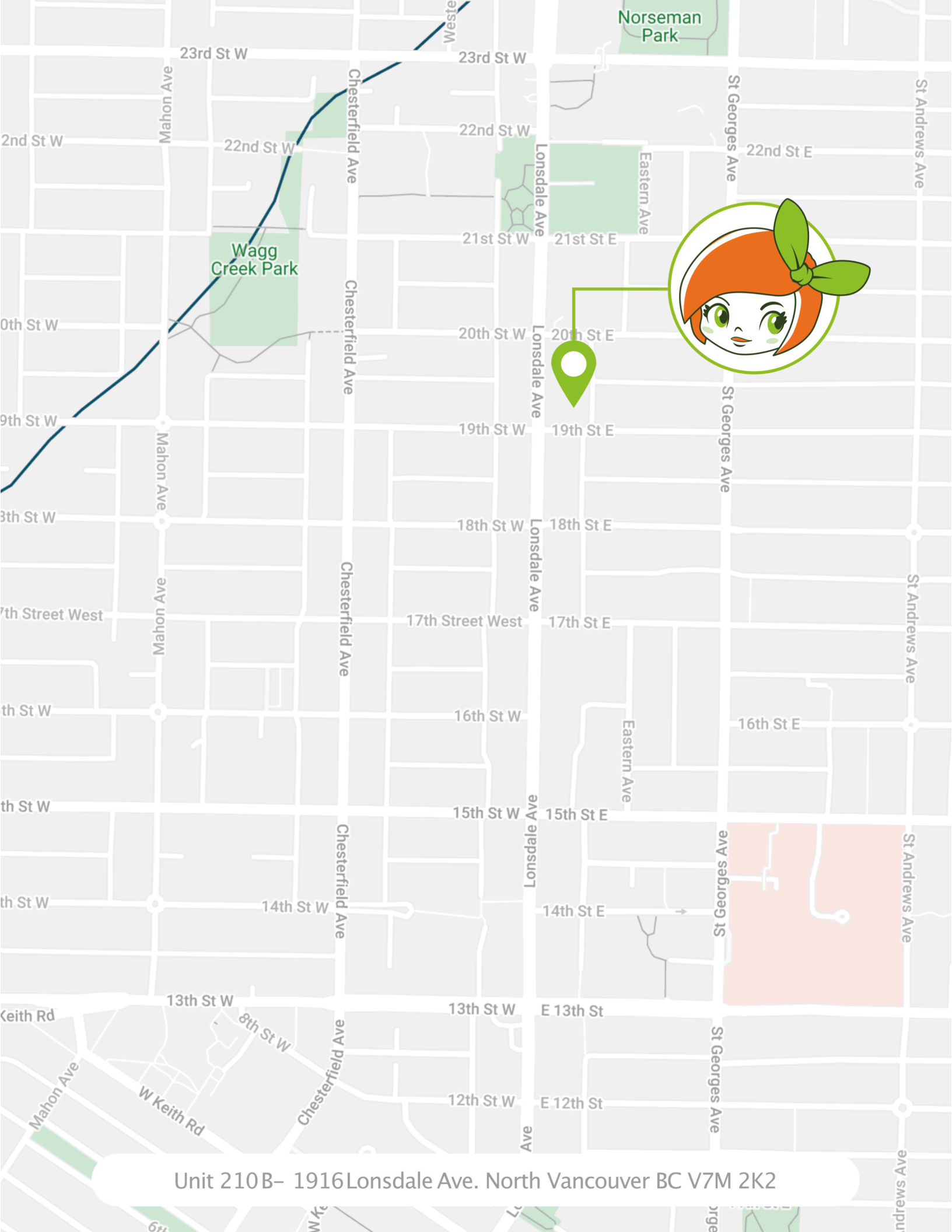
Radiographs are sent:

- ☐ By E-mail
- ☐ By mail
- ☐ With patient
- ☐ Other

Comments

778-907-7111 | info@toothfairykids.ca | toothfairykids.ca

Unit 210 B- 1916 Lonsdale Ave. North Vancouver BC V7M 2K2



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