

PATIENT REFERRAL

NAME _____

AGE _____

PHONE _____

REFERRING

DOCTOR _____

signature _____

date _____

REASON FOR REFERRAL, TREATMENT GOALS, COMMENTS:

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o: 403.253.2702
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Darin J Ward, DDS, FAGD, FRD(C)
SPECIALIST IN ORTHODONTICS

PERIODONTAL:

- No periodontal concerns
- Previous history of periodontitis, but not currently active
- Specific periodontal concerns: _____
- Continued care with referring office
- Patient may be referred to periodontist

RESTORATIVE & COSMETIC:

- All pre-orthodontic restorative treatment is complete
- Pre-orthodontic treatment yet to be completed: _____
- Post-orthodontic restorative treatment proposed:*
- Veneers Crowns/Onlays Bridges Implants
- Other: _____

PATIENT MOTIVATION:

- Patient understands the need for orthodontic treatment
- Patient is primarily concerned with:*
- Aesthetics Function Discomfort(TMD)
- Tooth loss Other

Patient is:

- Highly Motivated Indifferent Apprehensive

TMD:

- Patient has no history, signs, or symptoms of TMD or related disorder
- Patient does have a history of TMD or related disorders

ORAL SURGERY:

Teeth planned for extraction: _____

SUBMIT VIA:

FAX

403.259.2703

WEB clearorthodonticsolutions.ca/referrals