DENTAL REFERRAL FORM

LANDMARK DENTAL CENTRE

Suite 213 - 2506 Beacon Ave. Sidney, BC, V8L 1Y2

Phone: 250-656-4848 Fax: 250-656-5786

Email: admin@landmarkdental.ca

PATIENT INFORMATION

Patient Name: ______ **Gender:** ______ **Birthdate:** ______

Phone: ______ **Email:** ______

Address: ______

REFERRAL REASON IN DETAIL

Is this referral urgent?

☐ YES ☐ NO

Reason for referral (select all that apply):

☐ Bone Graft ☐ Implants: placement only

☐ Gingival Graft ☐ Implants: placement & crown

☐ Extractions ☐ Crown Lengthening

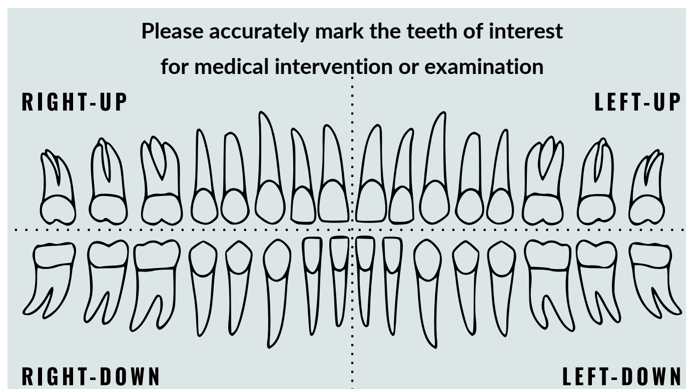
☐ Endo: RCT only ☐ Tissue Regeneration

☐ Endo: RCT & crown ☐ CT Imaging (please specify)

☐ N2O Sedation Required

☐ In-Hospital Dental Treatment (see eligibility criteria)

Please accurately mark the teeth of interest for medical intervention or examination



In-Hospital Dental Treatment Eligibility Criteria:

☐ The patient's age, health history, or mental disability renders treatment unsafe or impractical outside a hospital

☐ The procedure is highly complex or invasive, necessitating general anesthesia

☐ The patient is hospitalized and the procedure is essential for their medical care

☐ A medical contraindication (eg. Allergy) prevents the use of local anesthesia

☐ Limited access to the airway or surgical site presents a significant anesthesia risk in non-hospital settings

☐ Other circumstances where in the opinion of the dentist/oral maxillofacial specialist or attending medical practitioner, hospitalization is required for proper performance of the procedure

Images:

☐ Xrays included ☐ CBCT included

Further Instructions:

SIGNIFICANT MEDICAL CONDITIONS

REFERRING DENTIST INFORMATION

Dentist Name: ______ **Clinic:** ______

Phone: ______ **Email:** ______

Address: ______

PLEASE READ THE FOLLOWING CAREFULLY AND SIGN BELOW

By signing below, I acknowledge that I have discussed the referral with the patient and provided them with information about Dr. Justin Patterson's services. I have fully disclosed to the patient that Dr. Patterson is not a specialist. He is a general dentist with a special interest in oral surgery and endodontics. I understand that Dr. Patterson will evaluate the patient and provide necessary treatment or recommendations. The patient will be referred back to me for continued care and follow up.

Date: ______ **Signature:** ______