REFERRING DENTIST:

Southland Surgical Centre
105, 7 Strachan Bay SE
Medicine Hat, Alberta T1B 4Y2
Phone (403) 526-0067
Fax (403) 526-2414
Email: megdavis@southlandsurgical.ca

WE ARE REFERRING:

Patient Name: _____ **Birthdate:** _____ **Phone:** _____

Address: _____

_____

_____

Parent/Guardian: _____ **Phone:** _____

_____

REASON FOR REFERRAL:

☐ **CONSULTATION RE:** _____

_____

_____

_____

_____

RELEVANT HISTORY: (provide any special factors – dental or medical – such as known allergies and specific medical problems relevant to diagnosis or treatment)

_____

_____

_____

☐ **Please call the patient**

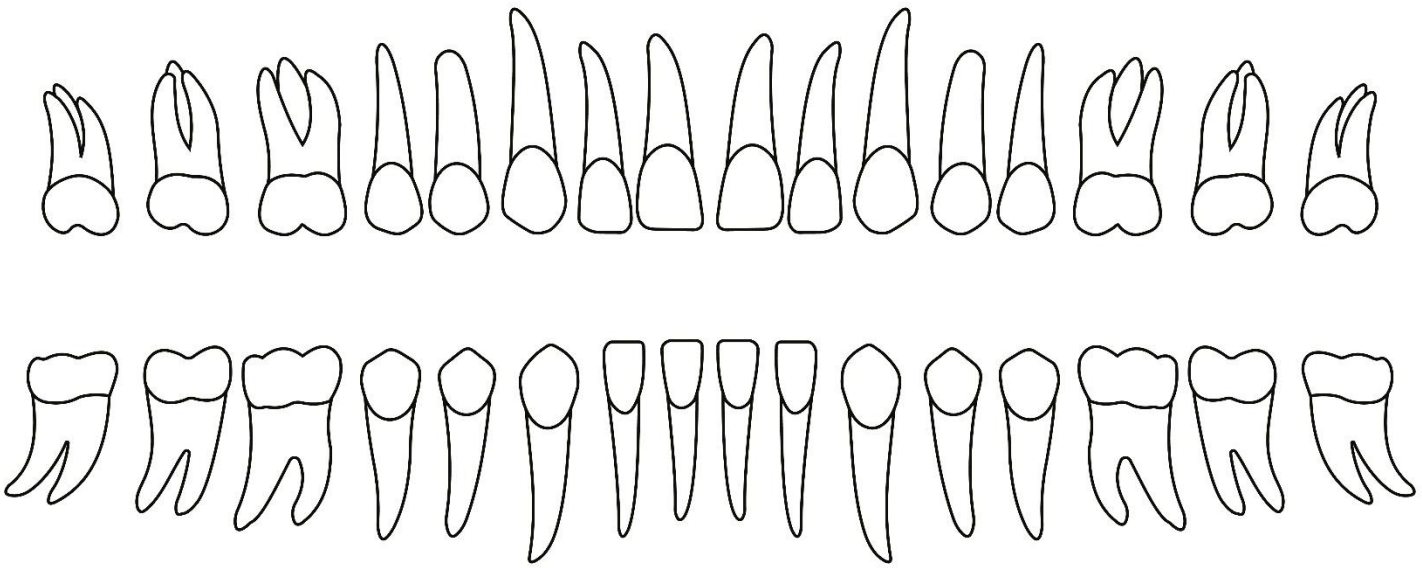
☐ **X-rays are enclosed (required)**

☐ **Return x-rays after use**

☐ **Book an appointment**

Report by: ☐ **Phone** ☐ **Written**

☐ **TREATEMENT (please provide appropriate details of the problem) _____**



SIGNED:_____ DATE: _____