GTA NORTH

PERIODONTICS & ENDODONTICS

DR. MAJID ZAKERI DDS, M.SC., FRCDC (PROSTHODONTICS)

DATE: _____

PATIENT TEL: _____

INTRODUCING: _____ Email Address: _____

Does the patient require antibiotics prior to dental treatment? Yes/No

REASON FOR REFERRAL

□ CONSULT ONLY □ CONSULT & TREATMENT □ SECOND OPINION

Urgency of care: □ Emergency care □ Urgent □ Routine

□ Limited treatment
□ Removable prosthetic(s)
□ Fixed prosthetic(s)
□ Cosmetic treatment
□ Implant-supported restoration
□ Full mouth rehabilitation
□ Other

RADIOGRAPHS/CLINICAL PHOTOS

□ ENCLOSED
□ WILL SEND VIA E-MAIL
□ PATIENT WILL BRING
□ NONE AVAILABLE

Relevant History: (indicate any special factors – either dental or medical – such as known allergies, and specific medical condition relevant to diagnosis and treatment)

Interim treatment that has been provided:

REMARKS:

REFERRING DR. _____

□ TEL: _____ □ E-MAIL: _____

PLEASE INDICATE YOUR PREFERRED METHOD OF CONTACT

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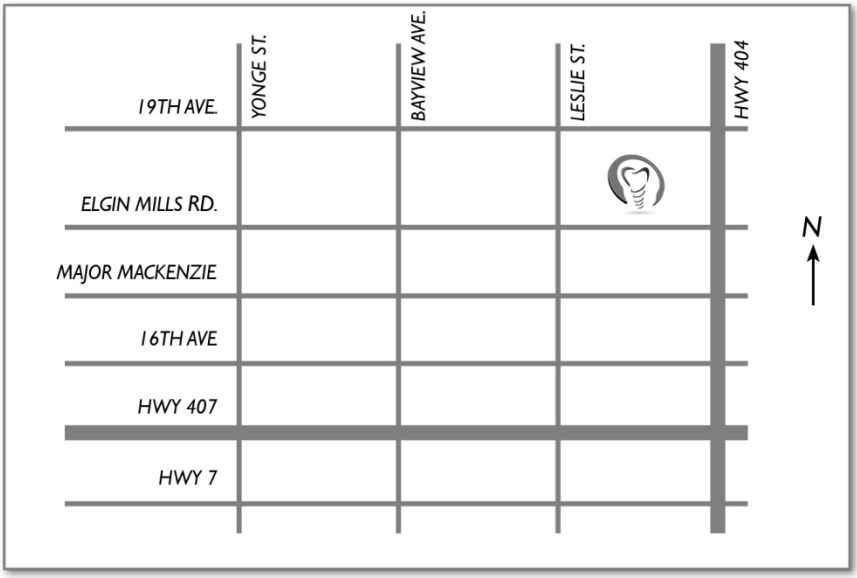

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