PATIENT REFERRAL FORM

Patient Information

Patient First Name: _____ **Patient Last Name:** _____

Parent's First Name: _____ **Parent's Last Name:** _____

Patient's Date of Birth Month _____ Day _____ Year _____

Telephone Number: _____ **Email Address:** _____

Referring Dentist Information

Dentist's First Name: _____ **Dentist's Last Name:** _____

Telephone Number: _____ **Email Address:** _____

Street Address: _____ **City:** _____

Province: _____ **Postal Code:** _____

HOW CAN WE HELP?

Please select at least one:

☐ Sleep Apnea Screening ☐ Laser Frenectomy ☐ Laser Snore Therapy

☐ Other (describe below)

Additional Comments: