DR. BORTOLUSSI & ASSOCIATE
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Date (D/M/Y):		Referral From (Dr. Name):	
Contact Number:		Office Number:	
Office Email:			
Patient Information			
Patient Name:			
D.O.B (D/M/Y)		Email:	
Telephone (H):		Telephone (M):	
Occupation:		W/O:	
Address:			
	(Street Number, Name, City, Province, Postal Code)		

Is the Patient in Pain?	Yes		No		Is Treatment Urgent?	Yes		No	

Reason for Referral

Radiographs Being Sent:	Yes		No		Date Obtained:

For Implant Referrals Does the patient already have placed implants? If yes, please list specifications pertaining to the implant (ie: location, size – diameter/length, brand, date placed):

Does the patient require Pre'med?	Yes		No	

Please list any systemic conditions, allergies, or other pertinent medical information