Phone: 902-843-3570
Fax: 902-893-8913
Email: TruroOralSurgery@gmail.com

REFERRAL TO: Dr. Louis Bourget

Date: ______________________

From: ________________________________
____
____

We are referring:

Patient's Name: ___________________________________

Address: ____
____

Birthdate: __________________ (M / D / Y) **Health Card:** ______________________

Parent/Guardian: __________________________

Telephone: __________________ **Alt. Telephone:** ___________________

REASON FOR REFERRAL:

□ **Consultation** □ **Treatment**

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Relevant History:

(Indicate any special factors – either dental or medical – such as known allergies and specific medical problems relevant to diagnosis and treatment.)

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□ **Please call patient** □ **Radiographs enclosed**

□ **Please report** □ **Written** □ **Telephone**

Signed: _____________________________ **Date:** ____________________