Dr. H. Ads
Oral Surgery
Limited General Dentist

Referral Form

Thank you for trusting us with your patient's surgical needs. Please fill out the form and email it to info@ivdent.com
We'll keep you updated and refer the patient back once the requested treatment is completed.

Patient Name _____ Age _____ Phone no. _____

Service Requested:

- ☐ Extraction
- ☐ Wisdom Teeth Removal
- ☐ Implants
- ☐ Bone Graft
- ☐ Ridge Augmentation
- ☐ Sinus Lift
- ☐ IV Sedation
- ☐ Other _____

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Preferred Location ☐ Orleans ☐ Kanata ☐ Ottawa

Referring DDS _____ DDS E-mail _____

X-rays ☐ Forwarded ☐ Given to patient ☐ On File ☐ Not Taken

Notes

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