APEX SURGICAL | Centre for Oral + Facial Surgery

REFERRAL FORM

DATE: DD | MM | YY REFERRING DOCTOR: _____

PATIENT'S NAME: _____

BIRTHDATE: DD | MM | YY SEX: ☐M ☐F

ADDRESS: STREET CITY PROV. POSTAL CODE

HOME PH: _____ WORK: _____ CELL: _____

EMAIL: _____

PARENTS NAME(S): _____
(WHEN APPLICABLE)

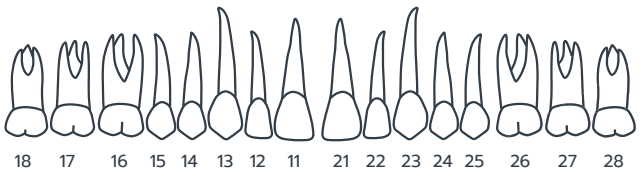
MEDICAL CONCERNS: _____

_____

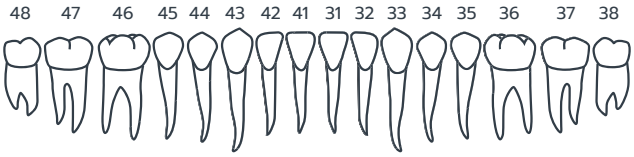
CONSULTATION REGARDING: _____

_____

☐EXTRACTIONS ☐IMPLANTS ☐EXPOSURE ☐ORTHOGNATHIC SURGERY
☐BONE GRAFTING ☐TMJ ☐PATHOLOGY ☐CLEFT LIP/PALATE
☐COSMETICS (BOTOX/FILLERS) ☐OTHER: _____



PLEASE INDICATE TEETH TO BE REMOVED WITH AN X



☐URGENT ☐CONSULT FIRST ☐CONSULT/SURGERY SAME DAY
RADIOGRAPHS: ☐NONE ☐WITH PATIENT ☐MAILED ☐EMAILED

(Minors under 18 years old should be accompanied by a parent or legal guardian)

DATE: DD | MM | YY TIME: _____ PHONE: _____

REFERRING DOCTOR: _____

FOR IV SEDATION PATIENTS:

- Nothing to eat or drink, including water for six (6) hours before appointment.
- All medications can be taken with a sip of water at regularly scheduled times.
- Please ask your pharmacy for a printed list of medications to bring to appointment.
- A responsible adult **MUST** accompany the patient on day of surgery and must remain in the office until the patient is discharged.
- Accepted methods of payment: Visa, MasterCard, debit, and cash. (Cheques NOT accepted)

DOCTOR'S COMMENTS:

Dr. Peter Stefanuto DDS MD MSc. FRCD(c) ORAL AND MAXILLOFACIAL SURGEON

206 - 755 McGill Road, Kamloops BC, V2C 0B6
Phone: 250-371-7076 | **Fax:** 778-765-8567 | **Email:** info@apexsurgical.ca