

REFERRAL TO DR. VICTOR WAGNER: FAX# 519-438-0066

REFERRAL FROM: Dr. _____
(first and last names please)

Phone # _____ Contact Name: _____

INTRODUCING:

Dr / Mr / Mrs /Miss / Ms _____
(please circle) (first name) (last name)

Telephone: H) _____ W) _____

Other) _____ Best to try first at: H / W / Other
(please circle)

Have we seen this patient before? Y / N Patient's birth date: _____
(Please circle) (month/day/year)

Patient's Address: _____

Patient is being referred for Tooth# or Area: _____

Requesting: Consultation / Consultation and Treatment at first visit
(if so, please send us a film)

Is this a retreatment? Y / N Is there a pulp exposure? Y / N

Has RCT already been started? Y / N if so, when? _____ and
has a temporary filling been placed in the access? Y / N

A film is being: Mailed / Pt. will bring / No film (please circle)

Pt. has been put on: Antibiotics / Pain Meds / No Meds (please circle)

If meds Rx'd. please list: _____

Discomfort? None / Mild / Moderate / Severe (please circle)

If applicable, please circle: Heat sensitivity / Pressure sensitivity / Cold sensitivity /
Throbbing pain / Facial swelling / Pain of unknown origin

Additional Comments and/or Any Major Medical Concerns: (ie: ProAb's etc.) _____

Thank you for your referral