VDSC
VANCOUVER DENTAL
SPECIALTY CLINIC

Vancouver Dental Specialty Clinic
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Patient Referral to:

☐ **Dr. Faranak Zaeimdar (Prosthodontist)** ☐ **Dr. Mohamed Gebril (Prosthodontist)**
☐ **Dr. Mehdi Noroozi (Periodontist)** ☐ **Dr. Jeffrey M. Coil (Endodontist)**

Referring Office Information:

Referring Doctor: _____

Address: _____

Phone: _____ **E-mail:** _____

Date of Referral: (DD/MM/YY) _____

Patient Name: _____ **Date of Birth:** _____

Phone: _____ **E-mail:** _____

Radiograph: **Emailed** ☐ **Take new** ☐
☐ **Please arrange the requested Consult / Treatment and refer the patient back.**
☐ **Consult Only** ☐ **Consult and Treatment**

Relevant Important Medical and Dental History:

Tooth/Site: _____

Reason for Referral:

☐ Oral Surgery ☐ Endodontics
☐ Periodontics ☐ Prosthodontics
☐ Implant ☐ Comprehensive dental care
☐ Oral Pathology ☐ TMD

Cone Beam CT acquisition:
☐ Single Arch ☐ Double arch

Additional notes:

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