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Fax: (416) 439-4203

40 Peel Centre Dr., Suite 119
Bramalea, Ontario L6T 4B4
Tel: (905) 792-2400

Date _____ Year _____

Introducing _____

Appointment _____

Day Date Time

There is a fee for consultation and radiograph and/or interpretation.
We will be pleased to complete an insurance form for you.

1	8	7	6	5	4	3	2	1		1	2	3	4	5	6	7	8	2
	Right									Left								
4	8	7	6	5	4	3	2	1		1	2	3	4	5	6	7	8	3

Doctor's Observation _____

- Patient requires prophylactic pre-medication
- Radiograph(s) attached Radiograph(s) emailed Pulp expose
- Restoration is cemented Temporarily Permanently

Prepare for post(s), which canal(s)? _____

Medications prescribed

- Patient requires sedation Nitrous oxide Oral* Intravenous*

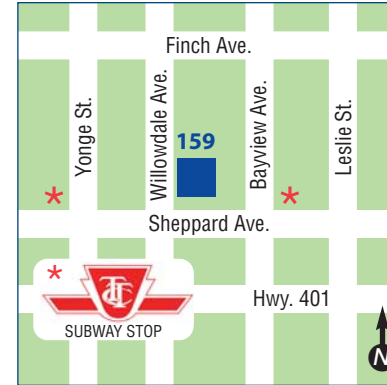
* A pre-treatment consultation is required for physical evaluation, confirmation of diagnosis and patient briefing.

Referring Dr _____

Office Address _____

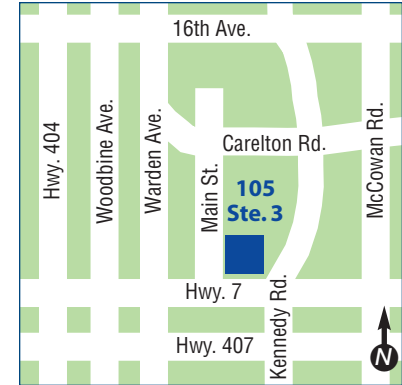
REFERRAL FORM

Willowdale Office



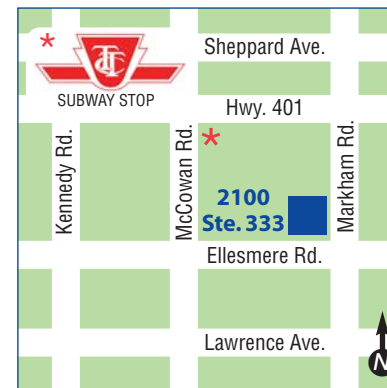
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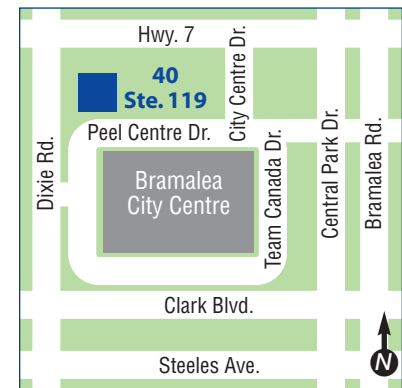
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Brampton Office



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ENDODONTIC ASSOCIATES