

Email to info@sjortho.ca, or give this sheet to the family to bring.

Questions: **(506) 633-0555**

REFERRING PRACTICE

Dentist

Practice

PATIENT

Full name

Date of birth (day, month, year)

Phone

Email

Parent or guardian, if under 19

Parent or guardian phone

REASON FOR REFERRAL (tick all that apply)

- | | | | |
|--|-------------------------------------|--|--|
| ☐ Crowding | ☐ Spacing | ☐ Crossbite | ☐ Deep bite |
| ☐ Open bite | ☐ Overjet | ☐ Underbite | ☐ Baby teeth lost early or late |
| ☐ Thumb or finger habit | ☐ Jaw growth | ☐ Jaw joint (TMJ) | ☐ Other (see notes) |

RECORDS SENT WITH THIS REFERRAL

- | | | | |
|--|--|---------------------------------|---|
| ☐ Panoramic x-ray | ☐ Cephalometric x-ray | ☐ Photos | ☐ Scan or models |
|--|--|---------------------------------|---|

Records are welcome but not required: every consultation includes our own digital x-rays.

OFFICE THE FAMILY PREFERS

- | | | | |
|-------------------------------------|-------------------------------------|--------------------------------------|--|
| ☐ Saint John | ☐ Quispamsis | ☐ St. Stephen | ☐ No preference |
|-------------------------------------|-------------------------------------|--------------------------------------|--|

NOTES FOR DR. MACKENZIE

Signature (type your name, or draw it)

Date

To draw it, use the Sign tool in your PDF app (Adobe Acrobat Reader: Fill and Sign; Preview on a Mac: Sign), or print and sign by hand.