



**Northland Oral & Maxillofacial
Surgery Centre**

referral
Northland Professional Building
Suite 204, 4600 Crowchild Trail NW, Calgary, Alberta T3A 2L6
Phone 403.286.5000 Fax 403.286.3333
info@northlandoralsurgery.com

FIRST AVAILABLE

DR. JAY LALLI

DR. SHAWN HIGASHI

Date: _____ Referring Dr.: _____

Dr.'s Ph.: _____ Dr.'s Location (if multiple): _____

Patient's Full/Legal Name: _____

Preferred/Nickname (if different): _____ Gender: M/F/Other

DOB (DD/MM/YY): _____ Parent/Guardian: _____

H #: _____ C #: _____

O #: _____ Email: _____

Insurance Carrier(s): _____

Reason for referral: (Check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> IV Sedation / General Anesthesia | <input type="checkbox"/> Socket / Ridge Preservation |
| <input type="checkbox"/> Wisdom Teeth Consult / Extraction | <input type="checkbox"/> Bone Grafting / Pre-prosthetic Surgery |
| <input type="checkbox"/> Extraction of Erupted Teeth | <input type="checkbox"/> Orthognathic / TMJ / CLP Consultation |
| <input type="checkbox"/> Expose / Bond Impacted Teeth | <input type="checkbox"/> Implant Consultation |
| <input type="checkbox"/> Trauma | <input type="checkbox"/> Pathology / Biopsy / Infection: _____ |

8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8
8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8
E D C B A	A B C D E
E D C B A	A B C D E

Medical / Additional Comments: _____

Imaging Date: (DD/MM/YY): _____ Sent Via: Email, Canada Post, Patient

Imaging Type: PAN, PA/BWs, Photos, CBCT, Other: _____