



REFERRING TO

Dr. Kirk Sutton
DMD, MSc, FRCD(C), Cert. Pros

Dr. Breanne Joslin
DMD, MSc, FRCD(C), Dip. Perio

▶ REFERRING DOCTOR

Referring Dentist: _____

Phone: _____ Date: _____

▶ WE ARE REFERRING

Patient Name: _____ Home Phone: _____

Date of Birth: DD / MM / YYYY _____ Cell Phone: _____

▶ REASON FOR REFERRAL

Implants:

- Surgical only, please return for prosthetics
- Prosthetics only
- Surgical and prosthetics

Grafting:

- Soft Tissue
- Hard Tissue

Perio Assessment: _____

Surgical Extractions: _____

Comprehensive Restorative Tx: _____

Occlusal Concerns: _____

TMD Concerns: _____



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



Comments: _____

- Radiograph Enclosed
- Please Send More Referral Slips