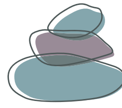
Kevin J. Robertson
B.Sc., D.D.S., F.R.C.D. (C)
www.foundationoralsurgery.ca
info@foundationoralsurgery.ca



foundation
oral surgery

#100, 628-12th Ave S.W.
Calgary, Alberta, T2R0H6
403-263-5193
800-879-2076
403-269-7557

Date of Referral: ______________________

Referring Doctor: ______________________ Phone: ______________

Patient's Name: ______________________ Patient's Gaurdian: __________

Address: ______________ City: __________ Postal Code: ________

Cell Phone: ______________ Email: ______________________

Patient's DOB: ______________ AHC# (if applicable) ______________

Primary Insurance: ______________ Secondary Insurance: ______________

Tx Request: ____

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Patient desires IV sedation or General Anaesthesia? ◯ Yes

Patient interested in consult and surgery on the same day? ◯ Yes

____
Doctor's Signature

X-Ray Information

◯ Pan ◯ P.A. ◯ CBCT Date of X-Ray: ______________________

Delivered by:

◯ Mail ◯ Patient ◯ Courier ◯ Email: info@foundationoralsurgery.ca

Please complete as much of this information as possible.
This will help all of us to give our very best to your patient(s).