artisanprosthodontics
DENTAL STUDIO

Dr. Tracey Clark BSc., DMD, MS, Prosthodontist | Dr. Todd Slogocki DMD, FRCD(C), Prosthodontist
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REFERRAL FORM

Date of referral: _____

Referral to: O Dr. Tracey Clark O Dr. Todd Slogocki O First available appt.

Referring Dentist information:
Name: _____
Address: _____
City/Town: _____ Postal Code: _____
Phone: _____
Email: _____

Patient information:
Last name: _____ First name: _____
Address: _____
City/Town: _____ Postal Code: _____
Phone: _____
Email: _____
Date of birth: _____ (Day / Month / Year)

Reason for referral:

_____
_____
_____
_____
_____
_____
_____

Please include relevant radiographs and reports.

RADIOGRAPHS (pantomographs, complete mouth series and periapical) can be emailed to:
artisan.dental.sask@gmail.com

Date: _____ Referring Dentist signature: _____

Printed Dentist name: _____