FUNDY DENTAL CENTRE
7322 Highway 1
Coldbrook, NS B4R 1B9
902-681-9111

Dr. Mubarak Alrafidi, BSc DDS
Dr. Scott Schofield, BScH DDS

Fundy Dental Centre – Referral Form

Date of Referral (DD-MM-YEAR): _____/_____/_____

Referring Dentist Info:

Name: _____
Office: _____
Address: _____
_____
Phone: _____

Referral To:

- ☐ **First Available Dentist**
- ☐ Dr. Scott Schofield
- ☐ Dr. Mubarak Alrafidi
- ☐ Dr. Mohamed El Azrak *(Pedodontist)*
- ☐ *Other*: _____

PATIENT INFORMATION

Name: _____ Birth Date (DD-MM-YEAR): _____/_____/_____
Address: _____ Health Card # _____
Town: _____ Prov: _____ Postal Code: _____
Home Ph: (_____)_____ Cell Ph: (_____)_____

☐ Internal Referral – *see attached patient visit form*

DENTAL COVERAGE

- Dental Coverage under government assistance? *(circle)* Social Assistance | Disability | MSI | NIHB | VA | CDCP
- Dental Insurance? Yes | No Secondary Ins.: Yes | No *(Our office will confirm details with the patient.)*

RELEVANT MEDICAL HISTORY

- Conditions: _____
- Medications: _____
- Allergies: _____

Height: _____
Weight: _____
BMI = _____

RADIOGRAPHS

Attached: ☐ CBCT ☐ PAN ☐ PA(s) ☐ BW(s) **Taken** (DD-MM-YEAR): ___/___/_____

Sent by: ☐ Hard Copy ☐ Emailed ☐ Uploaded - DS Core ☐ No images sent. Please take images.

REASON FOR REFERRAL

☐ Treatment ☐ Emergency (ASAP) ☐ Extraction ☐ Implant ☐ CBCT Only
☐ Consultation ☐ IV or N2O2 Sedation ☐ Restorative/Endo ☐ Pedo ☐ Other: _____

Treatment Plan/Additional Notes:

[OFFICE USE ONLY]

☐ Referral Tx approved w/ Dentist ☐ Patient Created in Dentrix ☐ Ref Imported ☐ X-rays Imported

Attempted Contact: (1st) _____ (2nd) _____ (3rd) _____ (4th) _____

Patient Booked: _____, _____ @ _____:_____ **am / pm**