



#251 - 1320 Trans Canada Hwy., Kamloops, BC, V1S 1J2
(250) 372-8578

Dr. Jaspal Sarao
B.D.S.D.M.D

Dr. Sunil Malhotra
B.D.S.D.D.S

REFERRAL

Referring Doctor: _____ Date: _____

Patient's Name: _____ DOB: _____

Address: _____ City: _____ PC: _____

Parent/Guardian: _____

Phone: _____ Cell: _____ Email: _____

Medical Concerns: _____

Consultation Regarding: Extraction Implants Sedation CBCT
 Full Arch Upper Arch Lower Arch Other

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18	17	16	15	14	13	12	11	■	21	22	23	24	25	26	27	28
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
48	47	46	45	44	43	42	41	■	31	32	33	34	35	36	37	38
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Special Instructions: _____

Please call patient Patient will call you X-rays emailed Please take X-rays

Insurance Information:

Name of Insured: _____ DOB: _____

Carrier: _____ Policy: _____ ID: _____

Dr. Email Address: _____ Dr. Phone #: _____

Email completed Referral Form to: info@deserthillsdental.ca