SMILE GARDEN
Dentistry from infancy to adolescence

Referral Form

Dr. Shannon Butler
D.D.S. M.S. FRCD(C)
Paediatric Dentist

Dr. Becky Olacke
D.M.D. M.S.D. FRCD(C)
Paediatric Dentist

Dr. Kristelle Bossé
D.M.D. – General Dentist
Practice Limited to Paediatrics

Dr. Paul MacDonald
D.D.S. FRCD(C)
Paediatric Dentist

Date: _____

Name: _____ DOB: _____

Parent / Guardian(s): _____

Telephone: (1) _____ (2) _____ (3) _____
Please provide two contact numbers

Medical History	☐ Healthy	Describe: _____	
Dental Benefits	☐ Private	☐ HSO / DCSP	☐ None
How can we help?	☐ Consult	☐ Treatment	☐ All

_____

_____

_____

_____

IMPORTANT – Please Help us to Triage your Patient

Urgency	☐ Trauma	☐ Swelling	☐ Severe Pain	☐ Antibiotic Rx
Treatment Attempted	☐ No	☐ Yes	☐ Nitrous Oxide	☐ Oral Sedation
Cooperation	☐ Poor	☐ Fair	☐ Good	
Parental Expectation	☐ N2O		☐ General Anesthetic	☐ Not Discussed
Radiographs	☐ No	☐ Yes	☐ Emailed	☐ Mailed
	Type: _____		Date: _____	

If this referral is an emergency, please contact our office by phone.
Please advise families the first visit is for a consultation only.

Referring Dentist: _____ **Office:** _____

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