



Patient name: \_\_\_\_\_ Date of referral: \_\_\_\_\_

Home Ph: \_\_\_\_\_ Work Ph: \_\_\_\_\_ Cell Ph: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Reason for referral: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Did you provide any treatment, and were there any treatment complications?  
\_\_\_\_\_

Medications prescribed? \_\_\_\_\_

Medical or dental history requiring special precautions? \_\_\_\_\_

**Forward info and current periapical radiographs securely via [www.ereferralservice.com](http://www.ereferralservice.com)**

Date of appointment: \_\_\_\_\_

Phones (403)263-1343 or (403)263-1344

Fax: (403)263-1345

**Suite 230, Bankers Court  
850 - 2nd Street SW, Calgary, Alberta, T2P 0R8**

Directions to our office on the internet at our website [www.bankershallendo.com](http://www.bankershallendo.com)