

**Certified Specialists in Pediatric Dentistry**

B107 - 2401 Millstream Road, Langford BC V9B 3R5 Ph: 250-478-5580 E: [info@treetopkids.ca](mailto:info@treetopkids.ca)

Referral Date: \_\_\_\_\_  
(mm/dd/yyyy)

Referring DDS/DMD: \_\_\_\_\_ Office Name: \_\_\_\_\_ Office Ph: # \_\_\_\_\_  
(full name)

Child's Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ M  F   
(first, middle, last) (mm/dd/yyyy)

Mother: \_\_\_\_\_ Ph#: \_\_\_\_\_ E: \_\_\_\_\_  
(home/mobile/work)

Father: \_\_\_\_\_ Ph#: \_\_\_\_\_ E: \_\_\_\_\_  
(home/mobile/work)

Guardian: \_\_\_\_\_ Ph#: \_\_\_\_\_ E: \_\_\_\_\_  
(home/mobile/work)

**Area of Concern:**

			<b>55</b>	<b>54</b>	<b>53</b>	<b>52</b>	<b>51</b>	<b>61</b>	<b>62</b>	<b>63</b>	<b>64</b>	<b>65</b>			
18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38
			<b>85</b>	<b>84</b>	<b>83</b>	<b>82</b>	<b>81</b>	<b>71</b>	<b>72</b>	<b>73</b>	<b>74</b>	<b>75</b>			

Comments: (medical history/behaviour/caries/other)

Radiographs:  Yes, emailed |  Yes, mailed |  No, not possible

Date Taken: \_\_\_\_\_  
(mm/dd/yyyy)

Insurance (1°): Co: \_\_\_\_\_ Policy Holder: \_\_\_\_\_ DOB: \_\_\_\_\_

Group #: \_\_\_\_\_ ID #: \_\_\_\_\_ Dependant: \_\_\_\_\_

Insurance (2°): Co: \_\_\_\_\_ Policy Holder: \_\_\_\_\_ DOB: \_\_\_\_\_

Group #: \_\_\_\_\_ ID #: \_\_\_\_\_ Dependant: \_\_\_\_\_

Please Fill Clearly and Email to [referrals@treetopkids.ca](mailto:referrals@treetopkids.ca)