Argyle ASSOCIATES

CARING. EXCELLENCE. TEAMWORK. COMMUNITY.

Oral Surgery Referral Form

Referral to Argyle oral & maxillofacial surgery

It is an honour to be included on your healthcare team. Thank you for entrusting your patients to us.
Complete the secure form online at argyleassociates.com, or print and return by fax or email. Fields marked * are required.

1 PATIENT INFORMATION

First name * | Last name * | Date of birth * (MM / DD / YYYY) | Date submitted * (MM / DD / YYYY)

Address | City | Province | Postal code

Cell phone * | Home phone | Email

2 REFERRAL INFORMATION

Requested surgeon (choose one)

- ☐ **First available**
- ☐ Dr. Ian Buckley
- ☐ Dr. Hassan G. Moghadam
- ☐ Dr. Kevin J. Butterfield
- ☐ Dr. Taylor P. McGuire
- ☐ Dr. Adam M. Irvine
- ☐ Dr. Andrew Wing Cheong Lee
- ☐ Dr. John E. Guenther
- ☐ Dr. Harshdeep S. Mangat

Preferred location

- ☐ **Barrhaven** — 3091 Strandherd Dr.
- ☐ **Carling & Surgicentre West** — 2255 Carling Ave.
- ☐ **Orleans & Surgicentre East** — 750 Taylor Creek Dr.
- ☐ **Kanata** — 499 Terry Fox Dr.

Referring dentist * | Referring dentist email *

Office name * | Additional care providers or specialist

Radiographs or documents included? ☐ Yes ☐ No ☐ Given to patient

Radiograph 1 date * (MM / DD / YYYY) | Radiograph 2 date (MM / DD / YYYY) | Radiograph 3 date (MM / DD / YYYY)

Required only when radiographs are sent — one date per image. Paper: enclose copies with this form. Online: up to 5 JPG, PNG or PDF files, 12 MB max each.

3 INSURANCE INFORMATION

Does the patient have dental insurance?
If yes, complete each policy that applies.

☐ Yes ☐ No

Primary policy

Policy holder first name | Policy holder last name

Gender (as registered with plan) ☐ Male ☐ Female

Policy holder date of birth: MM / DD / YYYY

Relationship to patient ☐ Self ☐ Parent ☐ Spouse ☐ Common-law

Insurance company

Group / plan / contract | Member / certificate ID

Patient is a student 21 or older? ☐ Yes ☐ No

School name (if student)

Secondary policy

Policy holder first name | Policy holder last name

Gender (as registered with plan) ☐ Male ☐ Female

Policy holder date of birth: MM / DD / YYYY

Relationship to patient ☐ Self ☐ Parent ☐ Spouse ☐ Common-law

Insurance company

Group / plan / contract | Member / certificate ID

Patient is a student 21 or older? ☐ Yes ☐ No

School name (if student)

4 TEETH OR AREA TO BE TREATED

Check each tooth to be treated. Chart is drawn facing the patient (FDI numbering).

◀ Patient's right — Patient's left ▶

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

For a lesion or area not tied to a tooth, select it under Treatment on page 3.

5 TREATMENT REQUESTED

Select one or more *

- ☐ Implants
- ☐ Extractions
- ☐ Impacted teeth
- ☐ Infection
- ☐ Orthognathic surgery
- ☐ Lesion
- ☐ Other

6 LESION OR OTHER DETAILS

Complete only if Lesion or Other is selected above. All fields required when it applies.

Location *

Measurement * mm

Shape *

Colour *

Duration — how long present? *

Symptomatic? *

☐ Yes ☐ No

7 ADDITIONAL COMMENTS

Reason for referral, "Other" treatment details, relevant medical history, urgency.

8 RETURN TO ARGYLE ASSOCIATES

Online
argyleassociates.com

Fax
613-778-8889

Email
patientservices@argyleassociates.com

Barrhaven
10-3091 Strandherd Drive
K2G 4R9

Carling & Surgicentre West
100-2255 Carling Avenue
K2B 7Z5

Orleans & Surgicentre East
750 Taylor Creek Drive
K4A 0Z9

Kanata
15-499 Terry Fox Drive
K2T 1H7