Argyle ASSOCIATES

CARING.
EXCELLENCE.
TEAMWORK.
COMMUNITY.

Pediatric Referral Form

Referral to Argyle pediatric dentistry

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 pediatric dentist (choose one)

☐ **Dr. Audrey Lacombe**
DMD, MSc, FRCDC, Dip. ABPD
Pediatric Dentist / Dentiste pédiatrique

☐ **Dr. Stéphanie Labbé**
DMD, MSc, FRCDC
Pediatric Dentist / Dentiste pédiatrique

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. 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

☐ **Lesion or other area** — not tied to a specific tooth. Describe it in Additional comments on page 3.

5 ADDITIONAL COMMENTS

Reason for referral, relevant medical history, behaviour or sedation considerations, urgency.

6 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