Argyle ASSOCIATES
ORAL & MAXILLOFACIAL SURGERY

CARING.
EXCELLENCE.
TEAMWORK.
COMMUNITY.

PEDIATRIC REFERRAL FORM

It is an honour to be included on your healthcare team. Thank you for entrusting your patients to us.

You may complete the secure online referral form or print and return this blank form to Argyle Associates.

An asterisk (*) indicates a required field.

PATIENT INFORMATION

First Name*

Last Name*

Date of Birth (mm/dd/yyyy)*

Date Submitted (mm/dd/yyyy)*

Address

City

Province

Postal Code

Home Phone

Cell Phone*

Email

REFERRAL INFORMATION

Requested Pediatric Dentist:

☐ **Dr. Audrey Lacombe**
DMD, MSc, FRCDC, Dip. ABPD
Diplomate, American Board of Pediatric Dentistry
Pediatric Dentist / Dentiste Pédiatrique

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

Select Location:

☐ Barrhaven ☐ Carling & Surgicentre West ☐ Orleans & Surgicentre East ☐ Kanata

Referring Dentist*

Referring Dentist Email*

Office Name*

Additional Care Providers or Specialist Name

Do You Have Radiographs or Documents to Upload? ☐ Yes ☐ No ☐ Given to Patient

If uploading radiographs, indicate the date of each image. If you upload 3 files, indicate 3 dates.

Date of Radiograph #1*

Date of Radiograph #2

Date of Radiograph #3

File Upload: attach relevant radiographs or documents. Online: up to 5 JPG, PNG, or PDF files, max 12 MB each.

Argyle ASSOCIATES
ORAL & MAXILLOFACIAL SURGERY

CARING.
EXCELLENCE.
TEAMWORK.
COMMUNITY.

PEDIATRIC REFERRAL FORM | CONTINUED

INSURANCE INFORMATION

Does the patient have insurance? ☐ Yes ☐ No

Complete the policy sections that apply to the patient.

PRIMARY POLICY INFORMATION

Policy Holder First Name

Policy Holder Last Name

Policy Holder Gender (as registered with dental plan) ☐ Male ☐ Female

Policy Holder Date of Birth

Policy Holder's Relationship to Patient: ☐ Self ☐ Parent ☐ Spouse ☐ Common-law

Insurance Company Name

Group/Plan/Contract

Member/Certificate/ID

Is the patient a student 21 years or older? ☐ Yes ☐ No

School Name

SECONDARY POLICY INFORMATION

Policy Holder First Name

Policy Holder Last Name

Policy Holder Gender (as registered with dental plan) ☐ Male ☐ Female

Policy Holder Date of Birth

Policy Holder's Relationship to Patient: ☐ Self ☐ Parent ☐ Spouse ☐ Common-law

Insurance Company Name

Group/Plan/Contract

Member/Certificate/ID

Is the patient a student 21 years or older? ☐ Yes ☐ No

School Name

Argyle ASSOCIATES
ORAL & MAXILLOFACIAL SURGERY

CARING.
EXCELLENCE.
TEAMWORK.
COMMUNITY.

PEDIATRIC REFERRAL FORM | CONTINUED

TEETH OR AREA TO BE TREATED

Check each tooth or area to be treated.

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

ADDITIONAL COMMENTS

LESION OR OTHER DETAILS

Please add additional details for the Lesion or Other selection.

Location*

Measurement*

Shape*

Color*

Duration (how long have they had it?)*

Symptomatic*

RETURN TO ARGYLE ASSOCIATES

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

Fax: 613-778-8889 | patientservices@argyleassociates.com | argyleassociates.com