NIAGARA PENINSULA ORAL SURGERY

☐ **St.Catharines**
163 Scott Street
T 905-934-5432 F 905-934-5444
stcath@niagaraoralsurgery.com

☐ **Welland**
477 King St. Suite 204
T 905-788-2100 F 905-788-2122
welland@niagaraoralsurgery.com

☐ **Niagara Falls**
5470 Drummond Road
T 905-353-0117 F 905-353-0555
nf@niagaraoralsurgery.com

Please send only one referral to one location, if your patient is willing to travel, please indicate the office(s)

☐ **Dr. Carriero** ☐ **Dr. Gervais** ☐ **Dr. Bosco** ☐ **Returning patient**

Patient: _____ ☐ M ☐ F DOB:_____
(Month / Day / Year)

Primary Contact Name: *(self/parent/ guardian/POA)*_____

Contact Number(s) -please indicate if ☐ cell (1) _____ 2) _____

Email :_____

Appointment information: Please note that an appointment will not be arranged until referral and radiographs are received

8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8
8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8

E D C B A	A B C D E
E D C B A	A B C D E

RECORDS: ***Please email all radiographs with referral***

☐ Please take radiograph ☐ Periapical(s): Date:_____ ☐ Panorex /Date : _____ ☐ CBCT

INSURANCE: ***remind patient to bring insurance card***

☐ Private insurance ☐ CDCP ID#_____ ☐ Ontario Works Balance $_____ ☐ ODSP ☐ HSO ☐ IFH

RELEVANT MEDICAL HISTORY: ***detailed list from pharmacy is preferred, and health card***

☐ Premedication: ☐ Anti-coagulant ☐ Diabetic ☐ Bisphosphonate **~ complete next line if anything is marked off**

Medication or reason :_____

REASON FOR REFERRAL:

□ Extraction □ Pathology /Biopsy □ Implantology (☐ Bicon or / ☐ Straumann) □ Orthodontic Exposure ☐ Other

_____

_____

_____

_____

Referring Doctor (Print) _____

Practice name: _____

Revised April 2025