West Vancouver Orthodontics
Certified Orthodontist Clinic

Orthodontics REFERRAL FORM

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1849 Marine Drive,
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Dr. Dalia Taher
BDS, M.Sc (Ortho). FRCD(c)
Certified Specialist in Orthodontics

PATIENT INFORMATION

Name: ____ Date: ______________________

Email: ____ Telephone: ______________________

Notes: ____

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REFERRING DENTIST

Name: ______________________________________ Clinic: ______________________________

Email: ____ Telephone: __________________

☐ ORTHODONTICS REFERRAL

- ☐ General Orthodontic Evaluation
- ☐ Orthognathic Surgery Evaluation
- ☐ Invisalign Consultation
- ☐ Pre-prosthetic / Pre-implant Treatment

Remarks:

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RADIOGRAPHS

☐ Will send ☐ None

HOW WOULD YOU LIKE US TO KEEP YOU UPDATED ON FINDINGS AND PROGRESS?

☐ Email a report ☐ Phone call ☐ Send a report by mail