

**Part 1 TREATMENT REQUIREMENT**

**Periodontics**

Dr. Tarek Ali, DDS, MSc, Dip. Perio, FRCD(C)  
 Certified Specialist in Periodontics

**Oral Surgery**

Dr. Henry Chang, DMD

**Endodontics**

Dr. Eman Moradi, DDS, MSc, FRCD(C)  
 Certified Specialist in Endodontics

**Orthodontics**

Dr. Tarun Dass, DDS, MDS (Orthodontics), BDS  
 General Dentist

**Implantology**

Dr. Shahdad Ayoughi, DDS, DMD, DICOI

**Part 2 REFERRAL INFORMATION**

**Date of Referral:**

Please use this part of the form to tell us about the patient. This may be you or the person on whose behalf you are making the referral.

Patient Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Address: \_\_\_\_\_

Referred By: \_\_\_\_\_ Tel: \_\_\_\_\_ Name of Office: \_\_\_\_\_

Patient or Parent's best Contact number: \_\_\_\_\_

Insurance Provider: \_\_\_\_\_ Policy/Contract: \_\_\_\_\_ Cert #: \_\_\_\_\_

Do you had an Xray recently taken?  Yes  No Date Taken: \_\_\_\_\_

If yes please email to: Parkviewdentalvancouver2018@gmail.com

**Part 3 OTHER DETAILS**

**Periodontal Therapy**

- Complete Periodontal Treatment
- Specific Area of Concern \_\_\_\_\_
- Guided Tissue Regeneration \_\_\_\_\_
- Soft Tissue Grafting \_\_\_\_\_
- Crown Lengthening \_\_\_\_\_
- Cosmetic Gingival Recontouring \_\_\_\_\_
- Tooth Exposure \_\_\_\_\_

**Orthodontics**

Reason for referral and condition \_\_\_\_\_

Comment for Specialist  
 \_\_\_\_\_

**Oral Surgery / Oral Sedation**

- Removal of 3rd Molars \_\_\_\_\_
- Pls. indicate tooth involved \_\_\_\_\_

**Implant**

- Single Tooth Implant placement
- Implants for Bridge
- Implants for Dentures
- Bone Grafts and Sinus Lift

**Endodontics**

- Chief Complaint: \_\_\_\_\_

**Appointment Information:**

This time is reserved specifically for you. If by necessity you must change your appointment, Please kindly notify us at least 3 business days in advance. See back for map

