VDSC
VANCOUVER DENTAL
SPECIALTY CLINIC

Vancouver Dental Specialty Clinic
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Email: info@vdsclinic.com
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Patient Referral to:

□ **Dr. Faranak Zaeimdar (Prosthodontist)** □ **Dr. Jeffrey M. Coil (Endodontist)**
□ **Dr. Mehdi Noroozi (Periodontist)** □ **Oral Surgery**
□**Dr. Rajan Saini (Oral Medicine and Oral Pathologist)**

Referring Doctor: _____ Date: _____

□ **Please arrange the requested Consult / Treatment and refer the patient back.**

□ Consult only □ Consult and Treat

Patient Name: _____ Date of Birth: _____

Phone: _____ E-mail: _____

Radiograph emailed □ Take new □

Relevant important Medical and Dental history:

Tooth/Site: _____

Reason for Referral:

□ Oral Surgery □ Endodontics
□ Periodontics □ Prosthodontics
□ Implant □ Oral Medicine Oral Pathology

Cone Beam CT Acquisition:
□ Full Arch □ Double Arch

Additional notes:

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