IMPrESS Perio Implant Center, Department of Prosthodontics
Unit 304-1901 Rosser Avenue
Burnaby BC V5C6R6
TEL: 604-733-4867
FAX: 604-294-9707
INFO@IMPLANTPERIOSPECIALIST.COM
WWW.IMPLANTPERIOSPECIALIST.COM

Patient Referral to: **Dr. Faranak Zaeimdar (Prosthodontist)**

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:

Additional notes:

____
____
____
____
____
____
____
____
____
____