VIVA ORTHODONTICS

CALL US
(289) 799-3999

WEBSITE
vivaortho.ca

EMAIL US
info@vivaortho.ca

VISIT US
105 Clappison Ave #104,
Waterdown, ON L8B 1W2

Orthodontic Referral Form

Thank you for trusting us with your patient's care.
Please complete and return this form along with any relevant records.

REFERRING DOCTOR / CLINIC INFORMATION

Doctor Name: _____

Clinic Name: _____

Clinic Phone number: _____

Clinic email: _____

PATIENT INFORMATION

Patient Name: _____

Patient DOB: _____ / _____ / _____

Patient Phone number: _____

Patient email: _____

REFERRAL DETAILS

What are your primary concerns regarding this patient? (Check all that apply)

- ☐ Class II
- ☐ Class III
- ☐ Deep Bite
- ☐ Open Bite
- ☐ Cross Bite
- ☐ Excessive Overjet
- ☐ Crowding
- ☐ Impacted Teeth
- ☐ Missing Teeth
- ☐ Other

RADIOGRAPHS

Radiographs will be:

- ☐ Emailed to info@vivaortho.ca
- ☐ Sent with the patient

HYGIENE (CLEANING)

Hygiene will be completed:

- ☐ At VIVA Orthodontics
- ☐ At referring office prior to orthodontic treatment

ADDITIONAL COMMENTS

*Please send any radiographs to **info@vivaortho.ca***