



5462 Signal Hill Centre SW  
Calgary, AB T3H3S8  
403-297-9600  
info@sierradental.ca

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**Abdo Fares**  
Denturist

Referring Dentist: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

We are referring:

Patient: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (Cell) \_\_\_\_\_ (Home) \_\_\_\_\_

Email: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Relevant History: (Indicate any special factors – either dental or medical- such as known allergies, and specific medical problems relevant to diagnosis and treatment)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please call patient

Radiographs are enclosed

An appointment has been made

Other Records are available

Referral sent by email on (date): \_\_\_\_\_