Ottawa West Dental – Surgical Services

Dr. Max Silver, DDS
Practice limited to Oral Surgery & IV Sedation Dentistry

Referring Dentist Information

Dentist Name: _____ Office Name: _____

Phone: _____ Email: _____

Patient Information

Name: _____ Date of Birth: _____ Phone: _____

Email: _____

Medical Conditions / Medications:

_____

Procedure Requested

- ☐ Simple extraction(s)
- ☐ Surgical extraction(s)
- ☐ Wisdom teeth
- ☐ Bone graft
- ☐ Gum graft
- ☐ Sinus lift
- ☐ Implant placement (Immediate / Delayed)
- ☐ Full-arch / All-on-X
- ☐ Crown lengthening
- ☐ Tooth exposure
- ☐ Biopsy
- ☐ IV sedation requested

Tooth number(s): _____

Radiographs and Supporting Documents

- ☐ Attached
- ☐ To be emailed separately
- ☐ Please take as needed

Additional Notes / Clinical Concerns

_____

Referring Dentist Signature: _____ **Date:** _____

Referral Acknowledgment

Thank you for trusting us with your patient's surgical care. All patients are returned to your care following surgical management, with clear communication and detailed post-operative notes provided.

Ottawa West Dental
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