Alberta Health Services

Division of Dentistry & Oral Health

Foothills Medical Centre
1403 - 29 Street NW Calgary, AB T2N 2T9
Telephone: 403-944-2401 Fax: 403-283-5260

Foothills Hospital Medical Centre
Special Needs Dental Clinic
Patient Referral Request

Patient Name: _____

Phone:
home _____ **work** _____ **cell** _____

Birth Date _____ /_____ /_____ **Alberta Health Care #** _____
yr month day

Dental Concerns:

_____

_____

_____**Specific Concern** _____**Comprehensive Treatment**

Medical Reason for Referral:

_____

_____

Current Medications: _____

_____

_____

Recent relevant radiographs: **mailed** _____ **yes** _____**no**
(Email digital radiographs to: fmc.dental@albertahealthservices.ca)

Referring doctor's name _____

Prac ID# __ __ __ __ __ - __ __ **0 8**

Phone _____

Fax _____

Does patient have dental insurance coverage?
_____ **yes** _____ **no**
if yes, Please provide the following information:

Insurance Company: _____

Group/Policy Number: _____

ID/Certificate Number: _____

For FMC Office Use Only

Please fax COMPLETED referral to 403 - 283 – 5260.
Our office will contact your patient for an initial consultation.
Please note our current waiting time for booking is 5 months.
Thank you for your referral.