DATE……

DOCTOR……

ADDRESS …… PHONE……

IS REFERRING……

ADDRESS …… PHONE……

REASON FOR REFERRAL……

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X-RAYS: ☐Mailed ☐E-Mailed ☐With Patient ☐None

DR. CARL YOUNG, DDS, MD, FRCD (C)
ORAL AND MAXILLOFACIAL SURGERY

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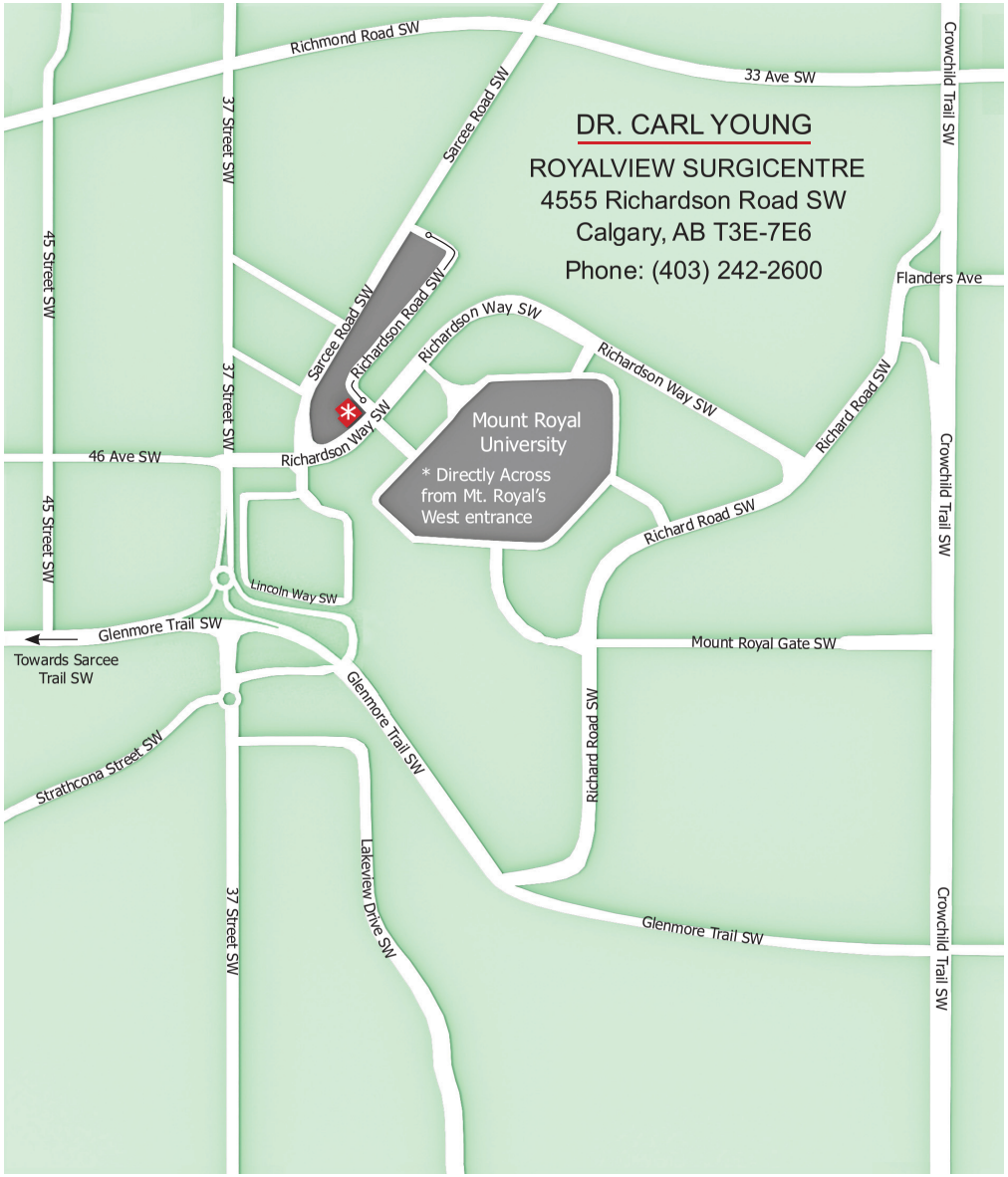
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