Delton Denture Clinic Referral Form

Delton Denture Clinic Ltd.
Denturist: *Chris Kozakiewicz*, RD
Denturist: *Kaja Olszewska*, RD
Suite 209 7313 120 Street
Delta BC V4C 6P5

Date:_____

ph: 604-590-1111
fax 604-501-2222

deltondentures.com

Referring Doctor's Name:_____ Office phone no:_____
Patient's Name:_____ Patient's phone no:_____

Reason for referral:_____

_____

_____

_____

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38

Existing Denture

- ☐ **Denture Repair**
- ☐ **Denture Reline**
- ☐ **Denture Soft Lining**
- ☐ **Adding tooth to partial**

New Denture

- ☐ **Complete Upper Denture**
- ☐ **Complete Lower Denture**
- ☐ **Cast Partial UPPER / LOWER Denture**
- ☐ **Acrylic Partial UPPER/LOWER Denture**

Immediate Denture

- ☐ **Complete Immediate Before Extractions**
  UPPER / LOWER / BOTH
- ☐ **Complete Immediate After Extractions**
  UPPER / LOWER / BOTH
- ☐ **Cast Partial Immediate Before Extractions**
  UPPER / LOWER / BOTH
- ☐ **Cast Partial Immediate After Extractions**
  UPPER / LOWER / BOTH

Denture over Implants

- ☐ **General Consultation Only**
- ☐ **Lower Denture 2-Implant Retained**
- ☐ **Screw Retained / Bar Retained**
- ☐ **All-ON-4**

Follow up Request

- ☐ **Please call patient for appt.**
- ☐ **Patient will call**
- ☐ **Please report on completion - written**
- ☐ **Please report on completion - by phone**