



**Gurjit Gakhal, DMD, FICOI.**

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Email: info@viewmontdental.com

Date of Referral:

Patient Name:

Contact #:

Patient DOB:

Contact email:

Referral For:

Pt requires IV for all treatment

Extraction(s):

IV for Extraction(s)

Implant(s):

Date tooth / teeth extracted:

Immediate Implant (s):  
(premolar and forward only)

Radiographs:  Not available  Enclosed / Emailed

Referring Doctor:

Plan holder's Name:

DOB:

Insurance Company:

Employer:

Group #

Policy ID:

Comments: