C A M C
Central Alberta **Maxillofacial** Centre
Suite 215 - 5201 - 43 Street, Red Deer, AB T4N 1C7
Ph: 403-347-4440 or 1-800-662-7175
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Oral & Maxillofacial Surgeon
Dr. Hajjaj Al-Hajjaj
B.D.S., MSc, M Dent, F.R.C.D. (c)

Please ensure ALL information is as complete as possible-Referral may be returned if incomplete

Date	Patient Name
Patient DOB (mm/dd/yy)	Patient Cell:
Parent/Guardian Name	Parent/Guardian Phone Number:
Address	
Referring Doctor / Clinic	Doctor/Clinic email address for reports

☐ **Dental Coverage: If your patient is covered by LIHB/AISH Program, please provide coverage Information: Group #** _____ **ID#** _____

Reason for Referral: _____

☐ Wisdom Teeth ☐ Dental Extraction(s) ☐ Bone Augmentation

☐ Implant(s) Location: _____

☐ Tooth exposure ☐ Tooth exposure with bracket bonding

☐ Temporomandibular Joint Disorder ☐ Pathology/Biopsy

☐ Post-Surgical Assistance

Teeth to be extracted:

55	54	53	52	51	61	62	63	64	65	
85	84	83	82	81	71	72	73	74	75	
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

Supernumerary: Area

Radiographs: ☐ Panoramic ☐ CBCT Date of x - ray _____
☐ Emailed ☐ Mailed ☐ With Patient

Notes: _____

URGENT ☐ Pain ☐ Infection ☐ High Risk Pathology ☐ Other