WINNIPEG
OROFACIAL HEALTH
CENTRE

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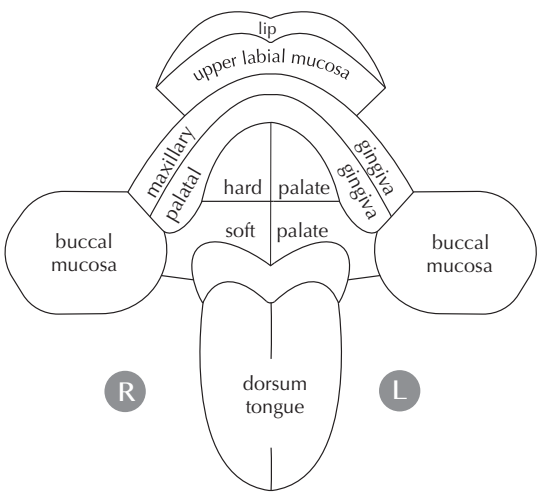
☐ Dr. Mohamad H. Kadhim, DDS, FRCDC (Oral & Maxillofacial Pathologist)
☐ Dr. Natasha Holder, DMD, MD, FRCDC (Oral & Maxillofacial Surgeon)

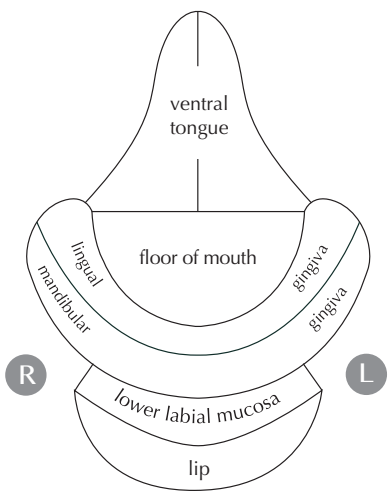
Patient's Name: _____ DOB: _____

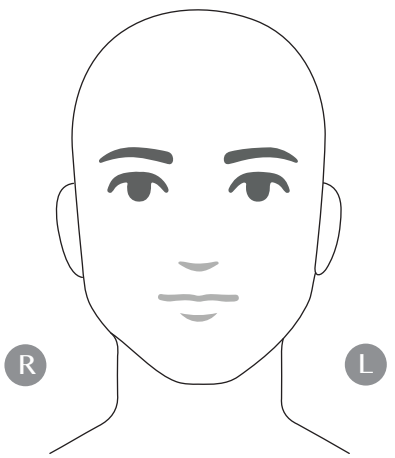
Email: _____ Phone: _____

Reason for referral:

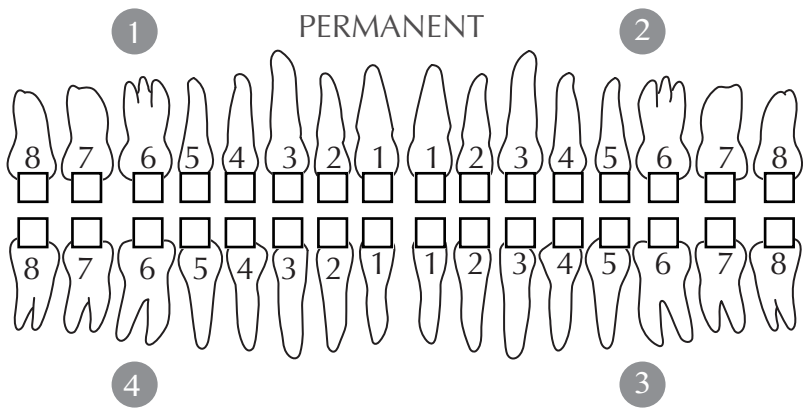
☐ Mucosal/Cutaneous Pathology + Biopsy:

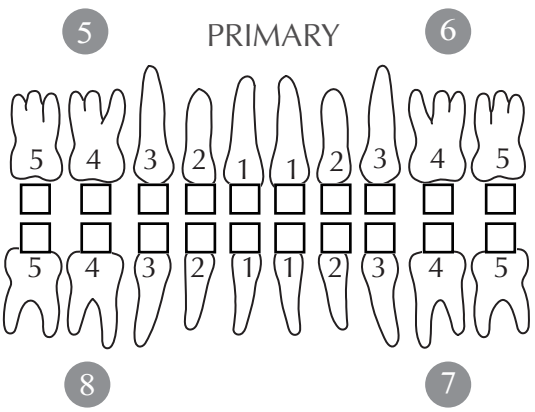






☐ Extractions: ☐ Third Molars





☐ Implant ☐ Pre-Prosthetic Surgery ☐ CBCT ☐ Orofacial Pain

☐ Bone Grafting ☐ Tooth Exposure ☐ TMD ☐ Other

☐ Comments/ Details: _____

_____

_____

_____ _____ _____

Referring Doctor Clinic Name Clinic Phone Number

Please send this referral form along with relevant radiographs/photos to:
email: info@orofacialhealth.ca or fax: 204-800-3030