Capital Health

ORAL & MAXILLOFACIAL SURGERY
REFERRAL FORM

Tel: (902) 473-2070
Fax: (902) 473-6855

From:

Dr.______________________________________
Mailing Address___________________________
City__________________________
Province___________ Postal Code___________
Phone: (____) ______-_______
Fax: (____) ______-_______

To:
(Please check one):

- □ Dr. Precious
- □ Dr. Goodday
- □ Dr. Morrison
- □ Dr. Davis
- □ Dr. Robertson
- □ Dr. Gregoire
- □ Resident
- □ Fellow

We are referring:

Patient's Full Legal Name: ____
(last) (first) (middle)

Date of Birth (y/m/d): _____________Gender: M/F _______ Provincial Health Card#:________________
Expiry Date _______________(y/m/d) Province: _______ If Ontario, card version: ___________________

Patient's Mailing Address: ____
____

City: ____________________________ Province: _________ Postal Code ______________
Home Phone # (_____)_________________________ Work Phone # (_____) __________________
Family Doctor: _______________________________

Reason for Referral:

□ **CONSULTATION RE**: ____
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□ **TREATMENT** (as requested):
(Please provide specialist with appropriate details of problem; i.e. urgency, areas of concern, using F.D.I. tooth numbering system.)
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RELEVANT HISTORY:
(Indicate any special factors – either dental or medical – such as known allergies and specific medical problems relevant to diagnosis and treatment.)
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- □ **An appointment has been made.**
- □ **Please report - written**
- □ **Please report – by phone**

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- □ **Radiographs are enclosed.**
- □ **Please return radiographs after use.**
- □ **Other records are available.**
- □ **Notify on completion.**

SIGNED: ____ **DATE:** _________________

Last date posted: November 25, 2010