

**Oral Care Program for
Medically Complex Patient
Dr. Samson Ng**



Department of Dentistry

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CONSULTATION REFERRAL to VGH REQUEST FORM

Today's date:

PATIENT NAME:

D.O.B.:

Address:

Phone:

REFERRING PHYSICIAN / DENTIST:

MSP #:

Referring Dr. Ph # :

Fax #:

MEDICATION (Please list): Patient Medical (PHN) #:

INVESTIGATION AND TREATMENT TO DATE:

Reason for referral specialty

Medical concern (please outline below)
