

UBC Graduate Program Clinics

2151 Wesbrook Mall, Vancouver, BC V6T 1Z3

Tel.: (604) 822-8078 Fax: (604) 822-3708

Date: _____

PATIENT:

Name: _____ Date of Birth: _____

Address: _____

Telephone (home) _____ (work) _____ (cell) _____

E-mail: _____

Dental Insurance: Yes No

Radiograph attached: Yes No Mailed separately: Yes No

REFERRING DENTIST:

Name: _____

Address: _____

Telephone: _____ Fax: _____

Email: _____

REFERRAL TO GRADUATE PROGRAM(S):

(for Endodontics use Endo Referral Form)

Orthodontics

Pediatric Dentistry

Periodontics

Prosthodontics

REASON FOR REFERRAL:

TOOTH # _____

MEDICAL HISTORY / ALERTS: