GERIATRIC DENTISTRY PROGRAM REFERRAL FORM

DATE: _____

PATIENT:

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

PERSONAL HEALTH NUMBER: _____ PHONE NUMBER: _____

NEXT OF KIN:

ADDRESS: _____

HOME: _____ WORK: _____ CELL: _____

E-MAIL: _____

RADIOGRAPH ATTACHED: ◯ YES ◯ NO MAILED SEPARATELY: ◯ YES ◯ NO

REFERRING DENTIST:

NAME: _____ BILLING #: _____

ADDRESS: _____

PHONE #: _____ FAX #: _____

E-MAIL: _____

REFERRAL TO:

- ☐ ORAL SURGERY
- ☐ ORAL MEDICINE
- ☐ VGH DENTAL CLINIC/ IV SEDATION
- ☐ GRAD PROS
- ☐ GRAD ENDO
- ☐ GERIATRIC DENTISTRY PROGRAM

DENTIST'S NAME & ADDRESS:

_____

CHIEF COMPLAINT:

_____

REASON FOR REFERRAL:

_____

MED HISTORY/ ALERTS:

_____

ADDITIONAL COMMENTS:

_____

2199 Wesbrook Mall Vancouver, BC Canada V6T 1Z3
Tel 604 822 8064 Fax 604 822 7736
gdp@dentistry.ubc.ca