



DENTAL REFERRAL

(PLEASE PRINT CLEARLY)

PATIENT INFORMATION					
Patient's last name:	First:	Middle:	<input type="checkbox"/> Dr. <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	<input type="checkbox"/> regularly in wheelchair <input type="checkbox"/> stretcher/bed <input type="checkbox"/> uses walker/ambulates
Address:	Phone no.:	Birth date: (D-M-Y)	Age:	Sex:	
	()	/ /		<input type="checkbox"/> M <input type="checkbox"/> F	

CONTACT INFORMATION			
Contact name:	Relationship to patient:	Home phone no.:	Work phone no.:
		()	()

REFERRING CLINICIAN				
Dentist Name:		Physician Name:		
Phone no.:		Phone no.:		
Fax no.:		Fax no.:		
Dental x-rays:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> mailed <input type="checkbox"/> sent with patient	Type:	<input type="checkbox"/> PAN <input type="checkbox"/> PAs
		Date taken:		

REASON FOR REFERRAL

MEDICAL/DENTAL INFORMATION		
Does the patient have any allergies (penicillin, latex, certain foods, other?)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the patient taking anticoagulants? If taking Coumadin, please attach last 3 INR results.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is antibiotic prophylaxis required for dental treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Please list any prescription or non-prescription drugs:		
Please list relevant medical history		

OTHER COMMENTS

PLEASE FAX THIS FORM TO THE BAYCREST DEPARTMENT OF DENTISTRY: (416) 785-2858