

BAYCREST HOSPITAL – DEPARTMENT OF DENTISTRY – ALPHA OMEGA DENTAL CENTRE

OUTPATIENT REFERRAL FORM

3560 Bathurst Street, Toronto, ON M6A 2E1 Tel: 416-785-2500 ext. 2600

Fax: 416-785-2858

Email: dental@baycrest.org

Patient InFormation Last Name Click here to enter text. Address Click here to enter text. Postal Code Click here to enter text. Date of Birth (MM/DD/YYYY) Gender Click here to enter text. Gell Number: Click here to enter text. Gell Number: Click here to enter text. Important of the provided of t	DATE: Click here to enter a date					
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				pharmacy-generated list.		



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condition affecting cooperativity, comment on ability to tolerate previous dental appointment(s) or procedures: Click here to enter text.	- If patient takes bisphosphonates (e.g., alendronate/Fosamax/Fosavance, risedronate/Actonel), how many years has the patient been taking them? Click here to enter text.
For patients with diabetes : - Does the patient get HbA1c checked? □ No □ Yes - What was the latest HbA1c value? Click to enter text. - When was it last checked? Click here to enter text.	- If patient receives injections of denosumab/Prolia, when was the last injection? Click here to enter text.
Other Comments: Click here to enter text.	

Note: referral must be typed. Incomplete or hand-written referrals will be returned.