

OUTPATIENT REFERRAL FORM

3560 Bathurst Street, Toronto, ON M6A 2E1

Tel: 416-785-2500 ext. 2600

Fax: 416-785-2858

Email: dental@baycrest.org

DATE: Click here to enter a date.			
PATIENT INFORMATION			
Last Name Click here to enter text.		First 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) Click here to enter text.	Gender M <input type="checkbox"/> F <input type="checkbox"/>
Home Number: Click here to enter text. <input type="checkbox"/> no home phone		Cell Number: Click here to enter text. <input type="checkbox"/> no cell phone	
Email Address: Click here to enter text.			<input type="checkbox"/> no email
Mobility information: <input type="checkbox"/> Ambulates without assistance <input type="checkbox"/> Uses wheelchair (can transfer to dental chair) <input type="checkbox"/> Uses wheelchair (cannot transfer to dental chair)			
CONTACT INFORMATION (if not same as above)			
Name Click here to enter text.	Contact number Click here to enter text.	Relationship to Patient Click here to enter text.	
		Power of Attorney Yes <input type="checkbox"/> No <input type="checkbox"/>	
REFERRING CLINICIAN			
Clinician Name Click here to enter text. <input type="checkbox"/> DDS <input type="checkbox"/> MD <input type="checkbox"/> RN		Clinic Phone Number Click here to enter text.	
Clinic Address Click here to enter text.		Clinic Fax Number Click here to enter text. Clinic Email Click here to enter text.	
REASON FOR REFERRAL			
Client's chief concern: Click here to enter text.			
<input type="checkbox"/> Specific treatment requested (specify) Click here to enter text.		<input type="checkbox"/> Provide comprehensive care (specify) Click here to enter text.	
Patient will return to referring dentist for continued care.			
Radiographs taken: <input type="checkbox"/> No <input type="checkbox"/> Yes If no, please provide reason: Click here to enter text.	Date taken: Click here to enter text. <input type="checkbox"/> Digital images sent	<input type="checkbox"/> PAs <input type="checkbox"/> BWs <input type="checkbox"/> PAN <i>If Digital radiographs were not taken, please have patient bring copies of analog radiographs to Baycrest appointment.</i>	
MEDICAL INFORMATION			
Medical History: Click here to enter text.		Medications/injections: Click here to enter text. <i>If more than 5 medications, include pharmacy-generated list.</i>	

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For patients with **dementia, Alzheimer's** or any condition affecting cooperativity, comment on ability to tolerate previous dental appointment(s) or procedures:

[Click here to enter text.](#)

For **osteoporosis** patients:

- 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.