Division of Dentistry

401 Smyth Road Web site: www.cheo.ca
Ottawa, ON K1H 8L1

REFERRAL FORM

Fax: (613) 738-4201
Telephone: (613) 737-2357

REFERRING PROFESSIONAL

Name: _____ Fax:_____

M.D. ☐ DDS/DMD ☐ Telephone:_____

Mailing Address:_____ Signature:_____

_____

PATIENT INFORMATION **DOB** _____ Sex: M ☐ F ☐
Year Month Day

Patient Name: print exactly as on Health Card

First Name: _____ Parent/Guardian Name(s):
_____

Surname: _____ _____

Home Address: _____ Telephone:

_____Postal Code _____ Home:_____

Health Card No. _____Version _____ Work (Mom):_____

Will an interpreter be required? Work (Dad): _____
No ☐ Yes ☐ Language _____

Other: _____

REFERRAL INFORMATION **Dental Insurance: _____**
Reason(s) for referral. Please provide relevant history and findings

_____

_____

MEDICAL INFORMATION

_____

_____

Current (< 6 months old) radiographs are requested:

Radiographs enclosed? Yes ☐ Type _____

No ☐ Reason: ☐ to follow by mail
☐ will bring to appointment
☐ unable to obtain, family aware that they may be taken at appointment

Clinic/Service Required

Dental ☐ **EMERGENCY** ☐ Yes ☐ No

Specialty ☐ _____

MOH Dental Program Funding Assessment ☐
(Eligible diagnosis must be noted above)

Upon acceptance of referral: WE WILL CONTACT THE PATIENT/FAMILY TO BOOK APPOINTMENT and will notify referring professional WITHIN 10 BUSINESS DAYS. Please instruct families NOT to call the clinic before this time.