Division of Dentistry

401 Smyth Rd
Ottawa, ON K1H 8L1
Web site: http://www.cheo.on.ca/en/dentistry

REFERRAL FORM

Fax: 613-738-4201
Telephone: 613-737-7600 ext 2358

PLEASE NOTE:

- Please fax the referral to the fax number listed above. Email referrals are not accepted.
- **All fields on this form must be completed prior to triage. Incomplete forms will be returned.**
- Upon acceptance of referral **we will contact the patient/family with the appointment date/time.**

PLEASE INFORM THE FAMILY:

- Once the referral has been triaged, an authorized or denied letter will be sent to the referring provider.
- **We are a paying clinic.** Payment will be due at every clinic visit or dental surgery appointment.

REFERRING PROFESSIONAL (PRINT CLEARLY)

Name: _____

☐ M.D. OHIP Billing Number_____
☐ DDS/DMD

Mailing Address: _____
_____

Referring Date:_____

Telephone:_____

Fax:_____

Signature:_____

PATIENT INFORMATION (As printed on Health Card)

First Name:_____

Surname:_____

DOB (Y/M/D): _____ Gender:_____

Home Address: _____

_____

Health Card #: _____

Version Code (2 letters):_____ Exp. Date: _____

Preferred language: _____

Will an interpreter be required? No ☐ Yes ☐

Parent(s) ☐ Legal Guardian ☐

Name: _____

Home :_____

Mobile :_____

Work :_____

DENTAL COVERAGE INFORMATION

No Insurance Coverage ☐

Healthy Smiles Ontario (HSO) ☐ #_____
Expiry Date: _____

Private Dental Insurance ☐

NIHB ☐ N#:_____

Refugee Status ☐ #:_____

MEDICAL INFORMATION / REFERRAL INFORMATION

Healthy ☐ Medically Compromised ☐ Special Needs ☐ MOH Dental Assessment ☐

Early childhood caries ☐ Pain ☐ Dental abscess ☐ Cellulitis ☐ Trauma ☐ Assessment/Regular care ☐

All radiographs must be sent by email at dentistry@cheo.on.ca.

Type of x-rays sent: BW ☐ PA ☐ Occlusal ☐ Panorex ☐ Date taken: _____

Details of reason(s) for referral. Please provide relevant history and findings:

_____
_____
_____
_____
_____
_____