The Ottawa Hospital | L'Hôpital d'Ottawa

Referral - Dental Clinic

Referrals are accepted by fax only, please send to:
Fax: 613-761-5134

REFERRAL INFORMATION

Referral Date (yyyy/mm/dd): | Referring Dentist / Physician:

Referral Address (full address required): | Telephone: | Fax:

Email:

PATIENT INFORMATION

Last Name (print): | First Name (print) | DOB (yyyy/mm/dd): | Gender:

Address: | Postal Code:

Email:

Contact Person's Name (Guardian/POA) (print): | Telephone: | Relationship

Mode of Transportation: ❑ Ambulance ❑ ParaTranspo ❑ Stretcher ❑ Wheelchair

INFORMATION MUST BE COMPLETED IN FULL -PRINT CLEARLY

Reason for Referral: ❑ Specific concern ❑ Comprehensive dental treatment

Dental Complaint & History / Proposed Treatment Plan:

_____

_____

_____

Dental Radiographs: ❑ None ❑ With Patient ❑ Digital X-rays (please send at time of referral to dentalclinic@toh.ca)

Relevant medical history that warrants treatment in hospital setting:

_____

_____

_____

Antibiotic Prophylaxis: Required for Dental Treatment? ❑ Yes ❑ No

Lab Results: Recent lab results (i.e: HbA1C, CBC, platelets, etc.) ❑ Yes ❑ No

Anticoagulants: ❑ Yes ❑ No
If yes, name of medication: _____ Last INR result: _____

Allergies: ❑ Yes ❑ No
If yes, specify: _____

Current Medication(s) (attach list):

Comments: