UHN Toronto General Toronto Western Princess Margaret Toronto Rehab Michener Institute

D 7 4 1 3

DENTAL CONSULTATION REQUEST

Department of Dental Oncology and Maxillofacial Prosthetics

610 University Avenue, Room 2 - 933
Toronto, Ontario M5G 2M9
Tel: (416) 946-2198
Fax: (416) 946-6576
Email: pmdentistry@uhn.ca

Date Received: _____

MRN: _____

Last Name: _____

First Name: _____

Date of Birth (dd/mm/yyyy): _____

Personal Health Information Label

PATIENT INFORMATION

Health card No.: **Version code:**		**Preferred Language:**
		Are Interpretation Services required? ❒ **Yes** ❒ **No**
Address:		
City:	**State/Province:**	**Postal Code:**
Home Phone No.:		**Alternate Contact Name:**
Cell Phone No.:		**Alternate Contact Phone:**
Work Phone No.:		**Relationship:**

CLINICAL INFORMATION

Inpatient: ❒ Yes ❒ No Inpatient Location: _____ Unit Ext: _____

Request: ❒ Urgent ❒ Routine

Reason for Consultation: _____

_____

If urgent, indicate why: _____

_____

Medical History: _____

_____

Medications: _____

_____

Is patient on or has previously received IV Bisphosphonates or anti-RANKL/VEGF/TKI/mTor treatment or similar?

❒ Yes ❒ No If so, how many doses: _____

PHYSICIAN OR DENTIST INFORMATION

Referring Physician Name:	Referring Physician Phone Number:	Referring Physician Fax Number:	Referring Physician Email Address:
Referring Dentist Name:	Referring Dentist Phone Number:	Referring Dentist Fax Number:	Referring Dentist Email Address:
Referring Clinician Address:		RCDSO #:	CPSO #:
		OHIP Billing #:	

Staff/Clinician PRINT NAME _____ SIGNATURE _____ DATE (dd/mm/yyyy) _____