VGH ORAL HEALTH CENTRE
Gordon & Leslie Diamond Health Care Centre
7th Floor - 2775 Laurel Street
Vancouver, BC V5Z 1M9

Telephone: 604-875-4006
Fax Requisition: 604-875-5493

VGH ORAL HEALTH CENTRE REFERRAL FORM

REFERRAL TO: ☐ HOSPITAL DENTISTRY ☐ ORAL MUCOSAL DISEASE PROGRAM ☐ OROFACIAL PAIN PROGRAM

Note: The VGH Oral Health Centre mandate is to treat patients with medical complexity or trauma requiring hospital service.

PLEASE PRINT CLEARLY ☐ ALLERGIES (PLEASE LIST):

BILLABLE TO: ☐ MSP ☐ ICBC ☐ WCB ☐ PATIENT ☐ OTHER	NAME / ADDRESS OF REFERRING PHYSICIAN or DENTIST AND MSP PRACTITIONER # (or office stamp)
PERSONAL HEALTH NUMBER: / DOB: YYYY/MM/DD	
SURNAME OF PATIENT, FIRST NAME AND MIDDLE INITIAL	
TELEPHONE# (INCLUDE AREA CODE): / ☐ MALE ☐ FEMALE PREGNANT: ☐ YES ☐ NO	
ADDRESS CITY/TOWN POSTAL CODE	COPY RESULTS TO:

☐ TRANSLATION SERVICES REQUIRED: (PLEASE INDICATE LANGUAGE) _____

PERTINENT HISTORY

REASON FOR REFERRAL (CHECK THOSE THAT APPLY):

☐ CENTRAL NERVOUS SYSTEM DISORDERS	☐ HEMATOLOGIC DISORDERS	☐ INFECTIOUS OR IMMUNE DEFFICIENCY
☐ CARDIOVASCULAR DISORDERS	☐ HEPATIC DISORDERS	☐ METABOLIC DISORDERS
☐ RESPIRATORY DISORDERS	☐ ENDOCRINE DISORDERS	☐ OTHER DISORDERS OF CONDITIONS:
☐ RENAL DISORDERS	☐ NEOPLASTIC DISORDERS	PLEASE LIST IN HISTORY

BRIEF HISTORY AND FINDINGS:

_____

_____

_____

CONTACT PERSON FOR APPOINTMENT IF NOT THE PATIENT

SURNAME, FIRST NAME TELEPHONE# (INCLUDE AREA CODE):

PLEASE ATTACH ALL RECENT BLOOD/LABORATORY/IMAGING & OTHER PERTINENT RESULTS

PLEASE NOTE

ALL REFERRAL INFORMATION MUST BE COMPLETED IN FULL. INCOMPLETE REFERRALS WILL BE RETURNED.

PLEASE ADVISE PATIENTS THAT ALL REFERRALS REQUIRE AN INITIAL CONSULTATION. TREATMENT MAY NOT BE PROVIDED AT THE FIRST VISIT.

A FEE MAY CHARGED TO PATIENTS WHO FAIL TO PROVIDE AT LEAST 24 HOURS NOTICE OF CANCELLATION FOR A SCHEDULED APPOINTMENT OR TEST

ACKNOWLEDGEMENT OF REFERRAL:

☐ YOUR PATIENT'S VGH ORAL HEALTH CENTRE CONSULTATION IS SCHEDULED ON _____

OUR FACILITY IS A FRAGRANCE FREE ZONE