VGH DENTISTRY, Gordon & Leslie Diamond Health Care Centre
7th Floor, 2775 Laurel Street, Vancouver, B.C. V5Z 1M9
Telephone: 604-875-4006, Fax: 604-875-5493

VGH DENTISTRY REFERRAL FORM

PLEASE NOTE: The VGH Dental Clinic treats patients with serious medical problems making it unsafe for them to seek care in a community setting.

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 WILL BE CHARGED TO PATIENTS WHO FAIL TO PROVIDE AT LEAST 48 BUSINESS HOURS NOTICE OF CANCELLATION FOR A SCHEDULED APPOINTMENT.

PATIENT	**REFERRING PHYSICIAN OR DENTIST**
SURNAME :________________FIRST NAME:_____________	NAME: ____
PHN: ____________________ BIRTHDATE: ___M___D____YR	ADDRESS: _____________________________________
PHONE: __________________ CELL: __________________	_____________________________________
ADDRESS: SUITE:______ STREET: ______________________	PHONE: ________________FAX: ______________________
CITY: ____	MSP PRACTITIONER # ________________________
PROV: _________________________PC ____________	

Translation services required ___ yes ___ no (Please indicate language) ___________________________

REASON FOR REFERRAL

____
____
____

MEDICAL HISTORY

____
____
____

CURRENT MEDICATIONS

____
____

ALLERGIES: ____

CONTACT PERSON FOR APPOINTMENT IF NOT THE PATIENT

SURNAME	FIRST NAME	PHONE

ACKNOWLEDGEMENT OF REFERRAL:

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

____

OUR FACILITY IS A FRAGRANCE FREE ZONE

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