Department of Dentistry
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Referral Request Cover Sheet

To ________________________ Fax ____________________ or *mailed* ☐

Date ________________________ Patient Name ________________________

In order to process your referral request, we require the use of the standard BCCH Referral Form, for this and all future referrals. **Please read the eligibility criteria listed below carefully. If the criteria are not met, your referral cannot be accepted.**

Submit using this form (attached) and fax or mail it to the address/fax number above.

The two essential areas that must be completed in order to process the referral are:

1. "Medical Information" which indicates why the patient is being referred to BCCH Dentistry vs. a community facility (eligibility).

   The eligibility criteria for treatment in our facility is as follows:
   - children under the age of 17 years with significantly compromising medical condition such as cancer, organ transplant, congenital heart disease, cleft lip and/or palate, craniofacial anomaly, physical disabilities, medically diagnosed behavior management issues such as developmental delay or autism, and healthy children 48 months of age and under with severe caries.

2. "Patient Information" including name as it appears on the Personal Health Care Card Number, Date of Birth, Home Address, Parent Name, all available contact telephone numbers and if an interpreter will be required. **Personal Health Care Card number is essential.**

> *Upon acceptance of referral:*
> **WE WILL CONTACT THE PATIENT / FAMILY TO BOOK APPOINTMENT** and will notify referring professional WITHIN 10 BUSINESS DAYS. Please instruct families **NOT TO CALL CLINIC** before this time.

Thank you for taking the time to complete this form.