CHILDREN'S & WOMEN'S HEALTH CENTRE OF BRITISH COLUMBIA
AN AGENCY OF THE PROVINCIAL HEALTH SERVICES AUTHORITY

BCCH Dentistry Referral Form

Department of Dentistry

Telephone: 604-875-2114 Fax: 604-875-2812

PART I – PATIENT INFORMATION

NOTE: Dentistry is NOT free at B.C. Children's Hospital. We charge Standard CDSBC Fee guide rates, on a fee for service basis.

SURNAME _____ FIRST NAME _____

☐ MALE ☐ FEMALE DOB _____/_____/_____ AGE _____
MONTH DAY YEAR

PHN _____ _____ PARENT'S NAME _____

ADDRESS _____

DAY PHONE _____ CELL PHONE _____ OTHER PHONE _____

EMAIL _____ IS AN INTERPRETER REQUIRED? ☐ YES ☐ NO LANGUAGE _____

DENTAL INSURANCE ☐ YES ☐ NO INSURANCE CO. _____ GROUP _____ ID _____ INSURED (% COVERAGE) _____

EMPLOYER _____ INSURANCE HOLDER _____ EMPLOYEES D.O.B _____

PART II – REFERRING PROFESSIONAL

REFERRING PROFESSIONAL _____ MD, DMD, DDS, OTHER _____

PHONE _____ FAX _____ EMAIL _____

MSP # _____

ADDRESS _____

NUMBER OF PAGES SENT _____ SIGNATURE _____

PART III – MEDICAL / DENTAL INFORMATION

Reason for Referral:
(Please provide a brief history, positive physical findings, relevant investigations, and current medication. Refer to Specialty Guidelines for more information. Attach a separate form if necessary).

RADIOGRAPHS WILL BE FORWARDED ☐ YES ☐ NO WE WISH RADIOGRAPHS TO BE RETURNED ☐ YES ☐ NO

PART IV – URGENCY OF REFERRAL *(Please Circle)*

I **II(a)** **II(b)** **III** **IV**

BCCH USE ONLY

CONSULTATION DATE _____ SURGERY DATE _____

DATE FAX RECEIVED _____ T1 WAIT TIME _____ T2 WAIT TIME _____

Upon acceptance of referral:
We will contact the patient / family **WITHIN** 10 BUSINESS DAYS, to book a consultation. Please instruct families **NOT** to call clinic before this time.
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Revised: May, 2010