BCCH Dentistry Referral Form
Department of Dentistry

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

Please note: Dentistry is NOT free at BC Children's Hospital. We charge pediatric BCDA Fee Guide rates.

PART I: Patient information

Surname	First name	DOB (mm/dd/yyyy)	Age

PHN (Care Card)	Gender ☐ Female ☐ Male ☐ Other	
Parent's surname	**Parent's first name**	**Interpreter required? ☐ Yes**
		Language

Day phone	Cell phone	Other phone	
Email address	**Mailing street address**	**City**	**Postal code**

Primary dental insurance ☐ Yes ☐ No

Insurance company	Group number	ID number	Insured (% covered)
Employer	**Insurance holder**		**Employee DOB (mm/dd/yyyy)**

PART II: Referring professional

Surname	First name	MD, DMD, DDS, OTHER
Phone	**Fax**	**Email address**

MSP number (If no MSP number, please advise family to get a referral from an MD.)

Mailing street address	**City**	**Postal code**
Signature		

PART III: Medical/dental information & reason for referral

(Please provide medical/behavioral diagnoses, current medications, identified dental Issues and relevant investigations.)

PLEASE PROVIDE PHOTOS/ RADIOGRAPHS, EMAIL TO: **dentalclinic@cw.bc.ca**

Upon acceptance of referral:
We will contact the patient / family to book a consultation if accepted. Please instruct families **NOT** to call the clinic.
Revised: March 2022