KELOWNA ORAL MEDICINE & TMJ CLINIC

REFERRAL FORM

Fax:1-888-463-0167
Tel: 236-301-5197
info@kelownaomtmj.ca

Date:

PATIENT INFORMATION
Full Name
PHN
DOB (mm/dd/yyyy)
Address
City
Province
PC
Home
Cell
Email

REFERRING CLINICIAN
Full Name
CDA/MSP No. (if available)
Office Name
Address
City
Province
PC
Phone
Fax
Email

INSURANCE

Primary
Name of Insured
Employer
Plan Name
Policy No.
ID No.
DOB

Secondary
Name of Insured
Employer
Plan Name
Policy No.
ID No.
DOB

REASON FOR THE REFERRAL LETTER ATTACHED

- ☐ Oral mucosal lesions
- ☐ Temporomandibular joint disorders
- ☐ Orofacial pain
- ☐ Burning mouth
- ☐ Sleep medicine
- ☐ Neuromodulator injection
- ☐ General Oral Pathology
- ☐ Headache/Migraine/Neuropathic pain

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Comment:

URGENT/EMERGENCY • Yes • NO

MEDICAL/SURGICAL HISTORY Letter Attached

ALLERGIES/MEDICATIONS Letter Attached

RADIOGRAPHS None by Mail by Email

RADIOGRAPHS OR CLINICAL PHOTOS: • PAN • Periapical • CBCT

We will contact the patient directly for an appointment.