Department of Dental Oncology and Maxillofacial Prosthetics
University Health Network – Princess Margaret Cancer Centre
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ORAL DIAGNOSTICS REFERRAL FORM
Oral and Maxillofacial Radiology & Oral Pathology and Oral Medicine

Referring clinicians will be contacted with the scheduled appointment and any subsequent results
Patients are expected to pay at the time of their appointment
Form must be filled out in its entirety to facilitate consultation booking

REFERRAL INFORMATION

☐ **ORAL AND MAXILLOFACIAL RADIOLOGY**
Dr. Robert Wood DDS, MSc, PhD, FRCD(C)
Dr. Jeff Chadwick DDS, MSc, FRCD(C), Dip ABOMR

☐ **ORAL PATHOLOGY AND ORAL MEDICINE**
Dr. Patricia Brooks DDS, MSc, FRCD(C), Dip ABOMP

PATIENT INFORMATION

Patients Name:	Title:	Date of Birth: DD MMM YYYY
Health Card Number:	Version Code:	Language:
Street Address:		
City:	Province:	Postal Code:
Home Phone: ( )	Work Phone: ( )	
Alternate Contact:	Relationship:	Phone: ( )

REFERRAL INFORMATION

Referring Physician	OHIP Number:	Phone: ( )
Referring Dentist:		Phone: ( )
Referring Clinician Address:		

CLINICAL INFORMATION

Request: ☐ Urgent ☐ Routine
Reason for Referral:
Pathology: ☐ Ulcer ☐ Swelling ☐ Red area ☐ White area ☐ Pain ☐ Other
Duration and Size:
Location:
Radiographic:
Medical History:
Medications:

All previous digital radiographs and photographs **must** be emailed to: marijun.lopez@uhn.ca
Printed x-rays will **not** be accepted. Please send duplicate films with patient.