Department of Dental Oncology and Maxillofacial Prosthetics
University Health Network – Princess Margaret Cancer Centre
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pmdentistry@uhn.ca

External Consultation Request

Referring clinicians will be contacted with the scheduled appointment
Form must be filled out in its entirety to facilitate consultation booking

PATIENT INFORMATION

Date:_____

Patients Name: (LAST, FIRST)	Title:	Date of Birth: (mm/dd/yyyy)
Health Card Number:	Version Code:	Language:
Street Address:		
City:	Province:	Postal Code:
Home Phone: ( )	Work Phone: ( )	
Alternate Contact:	Relationship:	Phone: ( )

REFERRING CLINICIAN INFORMATION

Referring Physician	CPSO #:	Phone: ( )
Referring Dentist:	RCDSO #:	Fax: ( )
Referring Clinician Address:		

CLINICAL INFORMATION

Request: ☐ Urgent* ☐ Routine	
Reason for Referral:	*If urgent, indicate why:
Medical History: If there is a cancer history, at what hospital was treatment provided:	
Medications: History of IV Bisphosphonate or anti-RANKL/VEGF/TKI/mTOR treatment:	

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.