UNIVERSITY OF ALBERTA

ORAL MEDICINE
Graduate Program
Referral Form

Fully complete forms should be faxed to 780.407.5694 or sent to oralmed@ualberta.ca; a copy should be saved at the referring office.

Date ______________________

PATIENT INFO

Patient's name ______________________ Birthdate (MM/DD/YYYY) ______________________

Preferred phone ______________________ PHN ______________________

Alternate phone ______________________ Email ______________________

Address ____

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REFERRED BY

Name ______________________ Email ______________________

Office phone ______________________ Fax ______________________

Address ______________________ Signature

______________________ ______________________

REASON FOR REFERRAL

- ☐ Urgent
- ☐ Routine

Check the box that pertains to referral:

- ☐ Oral lesions
- ☐ TMD or orofacial pain
- ☐ Dental sleep medicine

Radiographs

Must include a panoramic image (less than one year old) for TMD or orofacial pain referrals.

- ☐ None
- ☐ With patient
- ☐ Emailed

Indicate below the patient's main complaint, past treatment and current medications.

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Patients will be assigned to an oral medicine graduate student who, under the supervision of a licensed faculty member, will complete assessments and treatment. Our program does not provide medicolegal opinions or reports.

The Canadian Dental Care Plan is accepted.

Mike Petryk School of Dentistry
Kaye Edmonton Clinic - Level 8
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