REFERAL FORM

McGill Oral and M axillofacial Pathology and Oral Medicine Teaching Clinic

Faculty of Dental Medicine and Oral Health Sciences
Undergraduate Teaching Clinic
Oral and Maxillofacial Pathology / Oral Medicine
2001 McGill College Avenue, suite 10
Montreal, QC H3A 1G1
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Email: patients.dentistry@mcgill.ca

Patient being referred

Name : _____ Birth date: _____
Address: _____
_____
RAMQ number:
Telephone: _____
Email: _____

Reason for referral:

- ☐ Soft tissue lesion
- ☐ Possible biopsy
- ☐ Oral infection
- ☐ Oral ulcer(s)/non-healing ulcer(s)
- ☐ Leukoplakia/ white lesions
- … Stomatitis /burning mouth
- … Radiographic lesion
- … Desquamative gingivitis

Relevant history:

(Indicate any special factors, either dental or medical, such as known allergies, specific medical problems relevant to diagnosis and treatment.)

_____

Please ask the patient to bring their list of medications for the consultation.

Date : _____ Print clinician name : _____

License number: _____

Email or fax number (to receive a copy of the consultation) :

_____