

**THE HOSPITAL FOR SICK CHILDREN  
DENTISTRY REFERRAL FORM**

555 University Avenue  
Toronto, Ontario  
M5G 1X8

Web site HSC:  
www.sickkids.ca

Department of Dentistry  
Fax: (416) 813-6375

Telephone: Dental Clinic (416) 813-7433  
Orthodontic Clinic (416) 813-7435

**REFERRING PROFESSIONAL**

Name: \_\_\_\_\_

Professional Designation: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_

Signature: \_\_\_\_\_

**PATIENT INFORMATION**

HSC No: \_\_\_\_\_

Patient Name: print exactly as on Health Card

First Name: \_\_\_\_\_

Surname: \_\_\_\_\_

Home Address: \_\_\_\_\_  
\_\_\_\_\_

Postal Code \_\_\_\_\_

Health Card No. \_\_\_\_\_ Version \_\_\_\_\_

Will an interpreter be required?  
No  Yes  Language \_\_\_\_\_

Sex: M  F  **DOB** \_\_\_\_\_  
year month day

Parent/Guardian Name(s): M \_\_\_\_\_

F \_\_\_\_\_

Telephone: \_\_\_\_\_

Mother: (H) \_\_\_\_\_ (B) \_\_\_\_\_

Father: (H) \_\_\_\_\_ (B) \_\_\_\_\_

Other: \_\_\_\_\_

**MEDICAL INFORMATION**

**Reason(s) for referral**

Please provide a brief history, positive physical findings, relevant investigations and current medication. Refer to Specialty Guidelines for more information on eligibility criteria.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current (< 6 months old) radiographs are required for consultation.**

Radiographs enclosed? Yes  Type \_\_\_\_\_

No  Reason  to follow by mail

will bring to appointment

unable to obtain, family aware that they may be taken at appointment

**Clinic/Service Required**

Dental

Orthodontic

MOH Dental Program Funding Assessment

(eligible diagnosis must be noted above)

Preferred dentist: \_\_\_\_\_

**HSC USE ONLY**

Date Received: \_\_\_\_\_

HSC Dentistry Triage Comments: \_\_\_\_\_

Priority \_\_\_\_\_

Not accepted: Redirected    Returned for more information

Triaged by: \_\_\_\_\_

Entered in EXAN: \_\_\_\_\_ (Clerk's initials)

Appt. Time \_\_\_\_\_

Referring doctor notified \_\_\_\_\_ (Clerk's initials)

Medical Alert Code(s): \_\_\_\_\_

Transaction Code(s): \_\_\_\_\_

Upon acceptance of referral: WE WILL CONTACT THE PATIENT/FAMILY TO BOOK APPOINTMENT and will notify referring professional WITHIN 10 BUSINESS DAYS. Please instruct families NOT to call the clinic before this time.