Vancouver Aboriginal Health Society

VAHS – EAST SIDE DENTAL CLINIC
REFERRAL FORM

Date: _____

LAST NAME: _____ FIRST NAME:_____

DOB (mm/dd/yy) _____PHONE#: _____EMAIL_____

HOME ADDRESS _____CITY_____POSTAL _____

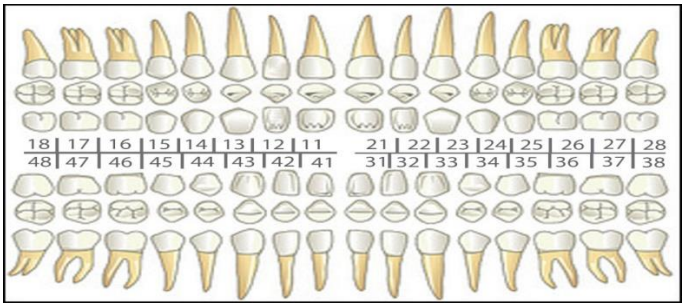
PHN (CARE CARD)# _____ABORIGINAL STATUS CARD #_____

OTHER ID# (PAROLE, REFUGEE): _____

INSURANCE COMPANY: _____POLICY# _____

GROUP# _____ DIV# _____OPTIONAL CODE_____ EMPLOYER _____

LAST DENTAL VISIT DATE: _____



Reason for referral:

- ☐ Cancer screening
- ☐ Consultation
- ☐ Ortho Consultation
- ☐ Dental filling
- ☐ Extraction (Simple / Surgical)
- ☐ Prosthetic treatment
- ☐ Root Canal Therapy
- ☐ X-ray (PA/CT/Panoramic)
- ☐ Other

_____

_____

Clinical Remarks:_____

_____

_____

_____

_____

Referred by Dr. _____
(NAME / SIGNATURE / CDSBC#)

"Your Patient's care is our focus!"
Please send a progress letter after the initial appointment

455 East Hastings St, Vancouver BCV6A 1P5
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