McGill | Faculty of Dental Medicine and Oral Health Sciences | Faculté de médecine dentaire et des sciences de la santé orale

REFERAL FORM

McGill Oral and Maxillofacial 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 100
Montreal, QC H3A 1G1
Telephone: 514-398-5081
Fax: 514-398-2089
Email : patients.dentistry@mcgill.ca

Patient being referred

Name: ______________________ Birth date: __________

Address: ______________________

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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.)

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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):

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