UNIVERSITY OF ALBERTA

ORAL MEDICINE GRADUATE PROGRAM
SCHOOL OF DENTISTRY
ORAL HEALTH CLINIC

Oral Medicine Graduate Program
Kaye Edmonton Clinic – Level 8
11400 University Ave.
Edmonton, AB T6G 1Z1
Tel: 780.407.5561
Fax: 780.407.5694
oralmed@ualberta.ca

Date: _____

Patient's Name: _____ Date of Birth (MM/DD/Year): _____

Address: _____

Home Phone: _____ Work/Cell #: _____

PHN: _____ Email address: _____

Referred By:
Referred by Dr.: _____

Address: _____

Office Phone: _____ Fax: _____

Email address: _____Signature: _____

Patient's chief complaint for referral:

_____

_____

_____

Please check the box that pertains to your referral:

Note: Patients will be assigned to an Oral Medicine Graduate Student as case manager for assessment and treatment. However, a supervising faculty member will review all assessments and oversee all treatment.

☐ **TMD / Orofacial Pain / Dental Sleep Medicine**

- **Please indicate past treatments and current medications in order to consider a consultation with us**

Please send a panoramic film (less than 1 year old) for TMD/Orofacial Pain referrals

- Our program does not provide medicolegal opinions or reports.

☐ **Oral Lesions**

☐ **URGENT** ☐ **ROUTINE** **Radiographs:** ☐ **None** ☐ **with Patient** ☐ **Emailed**

Please fax 780-407- 5694 or email oralmed@ualberta.ca this referral and we will contact the patient to schedule the appointment.

*** Please make copies of this referral form for your office***
All information must be complete on referral form must be completed – Thank you