Alberta Health Services

Last Name:	
First Name:	
DOB *(yyyy-Mon-dd)*	PHN:

Dental Clinic Referral

Date *(yyyy-Mon-dd)*	**Contact Information**	
	Legal Guardian Name *(if applicable)*	
Telephone Numbers for: ☐ Patient ☐ Legal Guardian		
Home:	Work:	Cell:
Behavioural, Functional Limitations:		
Relevant Medical Conditions:		
Allergies:	Medications: ☐ List attached, *if no, list below*	
Alerts		
☐ Anticoagulant Therapy *(specify):*		
☐ Antibiotic prophylaxis for dental treatment *(specify):*		
☐ Interpreter required *(Language):*	☐ Mobility: Lift Required	
Reason for Referral		
☐ Specific concern/ one time visit ☐ Comprehensive/ continuing care Details:		
Radiographs		
Please forward any dental radiographs taken within past 24 months ☐ Mailed ☐ Emailed to: fmc.dental@ahs.ca ☐ Sent with patient ☐ Unable to obtain. Patient/ family aware that x-rays may be taken at appointment.		
Referring Clinician	☐ Physician ☐ Dentist ☐ Nurse Practitioner ☐ Other:	
Name:	Phone #:	Fax #:
Practitioner ID Number*:		**Required for Alberta Health billing.*
Dental Clinic Use only		
Date received *(yyyy-Mon-dd):*		
Appointment Date *(yyyy-Mon-dd):*	Appointment Time *(hh:mm)*:	
Reply to Referring Clinician:		
Consulting Dentist Name:	Signature:	

Fax referral and any medication/ allergy lists to:
Foothills Medical Centre Dental Clinic at (403) 283-5260
When appointment is scheduled, the patient/family and referring clinician will be notified of date and time.