BCCH Dentistry Referral Form
Department of Dentistry

Telephone: 604-875-2114 Fax: 604-875-2812

Please note: Dentistry is NOT free at BC Children's Hospital. We charge pediatric BCDA Fee Guide rates.

PART I: Patient information

Surname	First name	DOB (mm/dd/yyyy)	Age
Miller	Liam	05/12/2018	7

PHN (Care Card)	Gender ☐ Female ☑ Male ☐ Other	
9876543210		
Parent's surname	**Parent's first name**	**Interpreter required? ☐ Yes**
Miller	Sarah	**Language**

Day phone	Cell phone	Other phone	
604-555-9999	604-555-0198	604-555-9999	
Email address	**Mailing street address**	**City**	**Postal code**
smiller@email.com	1234 Maple Leaf Drive	Vancouver	V6B 1A1

Primary dental insurance ☑ Yes ☐ No

Insurance company	Group number	ID number	Insured (% covered)
Pacific Blue Cross	888777	PBC123456789	80
Employer	**Insurance holder**		**Employee DOB (mm/dd/yyyy)**
Tech Solutions Inc.	Sarah Miller		02/20/1985

PART II: Referring professional

Surname	First name	MD, DMD, DDS, OTHER
Thorne	Marcus	DMD
Phone	**Fax**	**Email address**
604-555-7777	604-555-7778	

MSP number (If no MSP number, please advise family to get a referral from an MD.)

G998877		
Mailing street address	**City**	**Postal code**
456 Broadway St	Vancouver	V5T 1W4
Signature		
Dr. Marcus Thorne		

PART III: Medical/dental information & reason for referral

(Please provide medical/behavioral diagnoses, current medications, identified dental Issues and relevant investigations.)

Medical Diagnosis: Moderate Autism Spectrum Disorder.
Current Medications: 5mg of Melatonin nightly for sleep support.
Dental Issues/Reason for Referral: Significant early childhood caries that are difficult to manage in a standard office environment.

PLEASE PROVIDE PHOTOS/ RADIOGRAPHS, EMAIL TO: **dentalclinic@cw.bc.ca**

Upon acceptance of referral:
We will contact the patient / family to book a consultation if accepted. Please instruct families **NOT** to call the clinic.
Revised: March 2022