

## REFERAL FORM

McGill Oral and M axillofacial 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 Collegavenue, suite 00 Montreal, QCH3A 1G1 Telephone:514-398-5081 Fax:514-398-2089 Email: patients.dentistry@mcgill.ca Pa tient being referred Name: Birth date: Address: RAMQ number: Telephone: Email: Re ason for referral: ... Soft tissue lesion Leukoplakia/ white lesions ... Possible biopsy Stomatitis /b urning mouth ... Oral infection Radiographic lesion ... Oral ulcer(s)/n on-healing ulcer(s) Desquamative gin givitis Relevant history: (Indicate any special factors, either dental or medical, such as known allergies, specific medical problems relevant to diagnosis and treatment.) Please ask the patient to bring their list of medications for the consultation. Print clinician name: Date : \_\_\_\_\_ License number: Email or fax number (to receive a copy of the consultation)