THE BLOOR CLINIC
DENTAL SPECIALTY GROUP

ORAL MEDICINE REFERRAL PAD

Patient Name: _____

Gender: **M** **F** Age: D.O.B.:

Appointment Date/Time: _____

Referred by Dr. _____

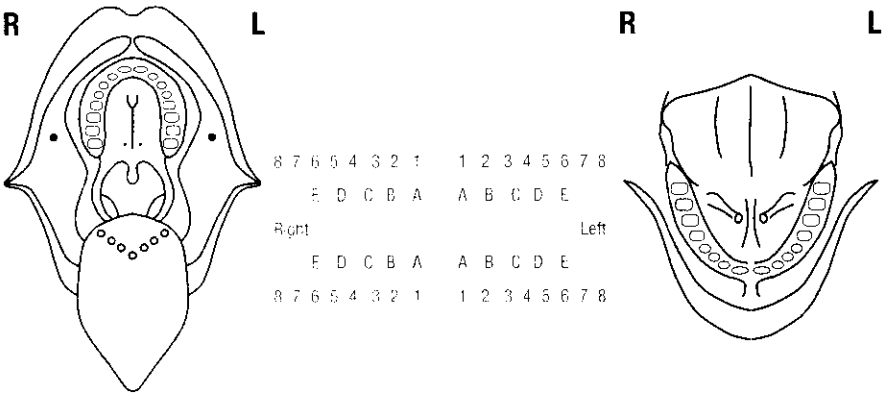
Regarding:

- ☐ Oral Cancer Screening
- ☐ Oral Lesion/Infection
- ☐ Orofacial Pain
- ☐ Dry Mouth

Other _____

Location/Distribution: _____

Please indicate the location of any lesions (use an X, arrow, or circle the affected area)



Clinical Appearance: _____

_____

_____

_____

Radiographic Appearance: _____

(See Back)

THE BLOOR CLINIC
3250 Bloor St. W, Suite 115 Concourse Level, East Tower - Bloor Islington Place | Toronto, ON, M8X 2X9
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Clinical Suspicion: _____

_____

Summary of History *(including Tobacco, Alcohol, Recreational Drugs)*

_____

_____

_____

_____

Checklist of Accompanying Materials: *(sent with patient/directly from referring office)*

- ❑ Comprehensive List of Medications/Dosages
- ❑ Radiographs *(no photocopies please)*
- ❑ Clinical Photographs
- ❑ Previous Biopsy Reports
- ❑ Medical Letters
- ❑ Laboratory/Diagnostic Reports
- ❑ Imaging Reports
- ❑ Blood Work

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