Dr. McCord Oral Pathology Referral Form

Dental Department
University Hospital Room B3-300
London Health Sciences Centre
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*****INFORMATION MUST BE COMPLETED IN FULL OR THE FORM WILL NOT BE PROCESSED- PLEASE PRINT CLEARLY*****

Date of Referral: _____ Appt Date: _____

Referred by Dr: _____ Phone# _____

☐ Dentist ☐MD OHIP Ref # _____

Patient Name (include guardian name if under 17): _____

_____

Date of Birth: _____ Health Card #: _____

Address: _____

City: _____ Postal Code: _____

Phone #: _____

****Urgency of Care**: ☐ Urgent ☐ Routine

Reason for referral (provide as much detail as possible): _____

_____

_____

_____

Type of Lesion: ☐Ulcer ☐Swelling ☐Red area ☐White area ☐Pain ☐Other

Location of Lesion: _____ Duration: _____ Size: _____

Previous Patient? ☐Yes ☐No

Dental X-Rays? ☐Yes ☐No ☐Email/Mail ☐With Patient

Clinical Photographs? ☐Yes ☐No ☐Email/Mail ☐With Patient

Other Information: _____

Signature: _____