Oral Pathology Clinic
Telephone: (902) 494-3868
oralpathclinic@dal.ca

Please send this form along with photos or radiographs to **oralpathclinic@dal.ca**.
We will contact your patient to arrange an appointment. **Referrals not using this format will not be accepted.**

REFERRAL TO THE ORAL PATHOLOGY CLINIC

REFERRING DENTIST INFORMATION:

Dentist Name: _____ ☐ General Dentist ☐ Specialist: _____

Address: _____ City/Postal Code: _____

Phone: _____

Email: _____

PATIENT INFORMATION:

Patient Name: _____ Date of Birth (MM/DD/YYYY): _____

Address: _____

Phone: Home: _____ Cell: _____ Work: _____

Email: _____

Reason for referral: (**Urgent referrals cannot be adequately accommodated in this clinic**)
Type of lesion:

☐ Ulcer ☐ Nodule/swelling ☐ White area ☐ Red area

☐ OTHER: _____

Location of lesion: _____ **Duration:** _____ **Size:**_____

Summary of Medical history with current medications:

Signature of the Referring Dentist: _____ Date: _____

As an educational facility:
- We welcome referrals that align with our undergraduate students training in general dentistry.
- If a patient is deemed unsuitable for the clinic, we will kindly refer them back to your office for continued care.