Eastern Health
Child/Women's Health Program

Dental Referral (Part I)

CL1440 0577 09 2015

Name:

HCN:

Date of Birth:

Date: DD/MONTH/YYYY

Parent's Names: _____ _____

Telephone (Home) _____ (Work) _____

(Cell) _____

Address (P. O. Box) _____ Street _____

City/Town _____ Postal Code _____

REASON FOR REFERRAL ❑ Medical Problem ❑ Uncooperative ❑ Other (Please explain below):

RADIOGRAPHS: ❑ None ❑ Included with referral ❑ emailed

SIGNIFICANT MEDICAL HISTORY (Please complete Questionnaire on Reverse Side - Pediatric Dentistry Only)

TREATMENT REQUIRED (Identify teeth and treatment) _____

_____

_____

_____

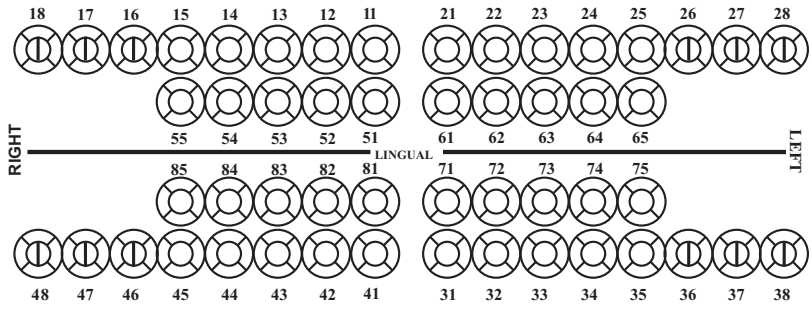
_____

_____

_____

INITIAL CLINICAL EXAMINATION:

DENTAL CHART



KEY
- Caries
- Filled
- Missing

Dentist's Name: _____

Dentist's Signature: _____ **Date:** DD/MONTH/YYYY

INITIAL HEAD/NECK/SOFT TISSUE:

INTRA ORAL: WNL (✔ if within normal limits)

Oro/Pharynx	☐	or _____
Tonsils	☐	or _____
Palate	☐	or _____
Periodontium	☐	or _____
Floor ofMouth	☐	or _____
Tongue	☐	or _____
Buccal Mucosa	☐	or _____
Head	☐	or _____
Neck	☐	or _____
Lymph Nodes	☐	or _____
Skin	☐	or _____

Comments: _____

_____

_____

_____

_____

Janeway Referrals:

Email: dentistry@easternhealth.ca
Fax to: 709-777-4171
Mail to: Janeway Dental Dept, Room 2J122
300 Prince Philip Drive
St. John's, NL A1B 3V6
Phone: 709-777-4437 - OR Bookings
709-777-4353 - Clinic Bookings

St. Clare's Referrals:

Fax to: 709-777-5899 (OR Bookings)
Mail to: OR Booking Office
St. Clare's Mercy Hospital
154 LeMarchant Road
St. John's, NL A1C 5B8
Phone: 709-777-5853 - OR Bookings

Eastern Health
Child/Women's Health Program

Dental Referral (Part II)

CL1440 0577 09 2015

Health Questionnaire

Name:

HCN:

Date of Birth:

Please answer the following questions

	YES	NO
1) Has your child ever been in hospital over night ? If yes: when, where, why?_____	☐	☐
2) Has your child ever had a general anesthetic or surgery? If yes: when, where, why?_____	☐	☐
3) Has your child ever had any problems with an anesthetic? If yes: explain _____	☐	☐
4) Has anyone in your family or a relative ever had a problem with an anesthetic? If yes: explain _____	☐	☐
5) Does your child have any allergies (including medications, food and latex)? If yes: please list _____	☐	☐
6) Is your child taking any medications now including ibuprofen and aspirin? If yes: Please list _____	☐	☐
a) Is your child on any puffers for asthma?	☐	☐
7) Does your child or anyone in your family have a bleeding disorder? If yes: Please explain _____	☐	☐
8) Has your child had any contact with any communicable diseases, such as chicken pox or measles, in the last month?	☐	☐

9) Does your child have any of the following conditions:

- ☐ heart problems or murmur
- ☐ cerebral palsy
- ☐ down syndrome
- ☐ spina bifida
- ☐ autism
- ☐ cystic fibrosis
- ☐ vp shunt
- ☐ seizures
- ☐ diabetes
- ☐ muscle disorders
- ☐ sleep apnea
- ☐ asthma
- ☐ hydrocephalus
- ☐ other, please explain: _____

10) Is your child being followed by a physician for any chronic health problem? Please explain _____	☐	☐

Signature _____ Date: DD/MONTH/YYYY

(parent or guardian)

Eastern Health acknowledges and respects the privacy of individuals. This personal information is being collected under the authority of Sections 32 and 33 of the *Access To Information and Protection of Privacy Act* and will be used to plan treatment appropriately. Please direct any questions about this collection to: Privacy Officer, Eastern Health, Quality and Risk Management, 12th Floor, Southcott Hall, 777-8025.