COVID-19 PATIENT REFERRAL FORM

We are referring:

Patient Name: _____
Phone #: _____
Email address: _____
Address: _____
Date of Birth: _____

Has Patient travelled outside of the Province/Country in the past 14 days: ____Yes ____ No

COVID-19 *RISK:* Is Patient experiencing any COVID-19/Flu symptoms (fever, dry cough, sore throat, loss of taste or smell); been in contact with someone who is being tested or who has been confirmed positive for COVID-19 (or experiencing symptoms)? ____ Yes ____ No

Details of patient's travel history and COVID-19 related symptoms: _____
_____

Provide details of patient's dental emergency including discussion of chief concern, decision to refer, tooth number(s), any treatment you have provided, and any other relevant dental history:
_____
_____
_____
_____

Relevant medical history:
(Please provide up to date medical history, including medications and allergies)
_____
_____
_____
_____

Name and signature of referring dentist:
_____

Phone number of referring dentist:
_____