Vancouver Native Health Society

VNHS – EAST SIDE DENTAL CLINIC
REFERRAL FORM

DATE: ______________________________

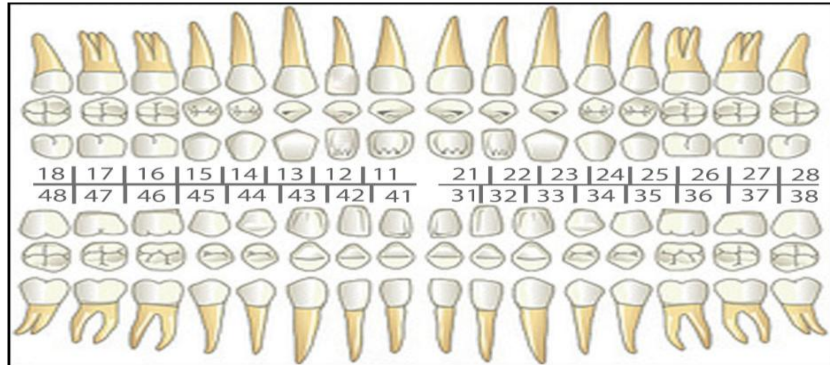
LAST NAME: ________________________ FIRST NAME: ______________________________

DOB (mm/dd/yy) ____________ PHONE#: ____________________EMAIL _______________

CARE CARD # ____________________ NATIVE STATUS CARD # ____________________

OTHER ID# (PAROLE, REFUGEE STATUS#): ____

TRANSLATOR'S CONTACT INFO: (if applicable): ______________________________________



Reason for referral:

- Cancer screening ☐
- Consultation ☐
- Dental cleaning ☐
- Others
- Dental filling ☐
- Extraction (Simple / Surgical) ☐
- Prosthetic treatment ☐
- Root Canal Therapy ☐
- X-ray (PA/Panoramic) ☐

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Clinical Remarks:

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Please include any dental record(s) if applicable by email or fax.

Referred by Dr. ______________________
(NAME / SIGNATURE / CDSBC#)

Contact info:

Rev. V.2 – 20181023

Thank you for the referral. "Your Patient's care is our focus!"
We shall send you a progress letter after the initial appointment

455 East Hasting St, Vancouver BC V6A 1P5.
T. 604.254.9900 / F. 604.254.9980 / E. dentalclinic@vnhs.net