NL Health Services

CHILD/WOMEN'S HEALTH

Dental Referral (Part I)

CL1440 0577 09 2015

Name:

HCN:

Date of Birth:

Date: DD/MONTH/YYYY

Parent/Guardian Name(s): _____ _____

Address: _____ City: _____

Province: _____ Postal Code: _____

Telephone (Cell): _____ Work: _____ Home: _____

Email: _____

Radiographs: ☐ None ☐ Emailed/CDAnet

Significant Medical History: ☐ Yes ☐ No If yes, list below and complete questionnaire on reverse side.

Treatment Required (Identify teeth and treatment):

Dental Office: _____

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

Janeway and St. Clare's Referrals:

Janeway Dental Department, Room 2J122
300 Prince Philip Drive
St. John's, Newfoundland and Labrador
A1B 3V6

Email: dentistry@nlhealthservices.ca
Telephone (Clinic Bookings): 709-777-4353
Telephone (OR Bookings): 709-777-4437
Fax: 709-777-4171

NL Health Services

CHILD/WOMEN'S HEALTH

Dental Referral (Part II)

CL1440 0577 09 2015

Name:

HCN:

Date of Birth:

Parent/Guardian to answer the following questions: **Yes** **No**

☐ Has your child ever been in hospital over night: ☐ ☐

If yes, when, where and why: _____

☐ Has your child ever had a general anesthetic or surgery: ☐ ☐

If yes, when, where and why: _____

☐ Has your child ever had any problems with an anesthetic: ☐ ☐

If yes, explain: _____

☐ Has anyone in your family or a close relative ever had a problem with an anesthetic: ☐ ☐

If yes, explain: _____

☐ Does your child have any allergies (including medications, food and latex): ☐ ☐

If yes, list: _____

☐ Is your child taking any medications now including ibuprofen and aspirin: ☐ ☐

If yes, list: _____

☐ Is your child on any puffers for asthma: ☐ ☐

☐ Does your child or anyone in your family have a bleeding disorder: ☐ ☐

If yes, explain: _____

☐ Has your child had any contact with any communicable diseases, such as chicken pox or measles, in the last month: ☐ ☐

☐ Does your child have any of the following conditions:

- ☐ Heart problems or murmer
- ☐ Down Syndrome
- ☐ Autism
- ☐ Sleep Apnea
- ☐ Seizures
- ☐ Muscle disorders
- ☐ Asthma
- ☐ Hydrocephalus
- ☐ Cerebral Palsy
- ☐ Spina Bifida
- ☐ Cystic Fibrosis
- ☐ VP Shunt
- ☐ Diabetes
- ☐ Other, specify: _____

☐ Is your child being followed by a physician for any chronic health problems: ☐ ☐

If yes, explain: _____

Parent/Guradian Name: _____ Signature: _____ Date: DD/MONTH/YYYY

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