Mount Hope Dental Clinic
21 Grosvenor St. London, ON 519-646-6022 Fax: 519-432-6527

Mount Hope Referral Form

Referring Dentist: _____ Date: _____

Phone: _____ Fax: _____ Email: _____

Patient's Name: _____ DOB: _____

Address: _____ City: _____

Postal Code: _____ Home Phone: _____ Other #'s: _____

Is the patient capable of making their own medical decisions? ☐Yes ☐No

Who should we contact to book the patient? _____

Reason for Referral:

_____

_____

_____

_____

_____

Radiographs available ☐Yes ☐No **Please email x-rays to: dental@sjhc.london.on.ca**

Medical History we should be aware of:

_____

_____

_____

_____

Is the patient ☐ Wheelchair bound or ☐ Mobile Is Lift Required ☐Yes ☐No

Are Antibiotics Required Before Dental Treatment ☐Yes ☐No

Dental Insurance ☐Yes ☐No : ☐ Government Program ☐ Private Insurance

Other Comments: _____

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