

REFERRAL OF DENTAL EMERGENCY

DATE: _____

REFERRING DENTIST: _____

CONTACT INFORMATION:

Email: _____

Phone number: _____

PATIENT'S NAME: _____

RAMQ NUMBER: _____

PREVIOUS MEDICAL HISTORY

Any serious pre-existing medical conditions?

diabetes heart disease cancer immunosuppression asthma

CURRENT MEDICATIONS: _____

ALLERGIES: _____

Current flu-like symptoms:

sore throat cough fever runny nose sneezing muscle aches shortness of breath

CURRENT DENTAL COMPLAINT:

Describe the chief complaint. Is this related to any dental treatment that you have provided in the past?

Do you have any previous X-rays of the affected teeth? Yes No

Have you attempted to treat this emergency pharmacologically? Please provide the details. Has there been any improvement?
