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DENTAL PROGRAM REFERRAL FOR SCHOOLS

The dental program staff may be able to assist families having difficulty accessing dental treatment. This includes urgent care or regular dental care. A referral form is not required if a parent or guardian prefers to contact the dental program directly at the telephone number below. Schools please fax or mail your referral to the appropriate health unit listed below.

Date: _____

Child's Name: _____

Child's Birth Date: _____

School: _____

Parent's/Guardian's Name: _____ Telephone: _____

Parent's/Guardian's consents to referral: Yes ☐ No ☐

To protect privacy, the child's parent or guardian must be aware that a referral is being made to the dental program.

Please describe the concern:

_____

_____

Referred by: _____ Telephone: _____
(Print Name)

Health Units with Dental Staff

Abbotsford HU 104-34194 Marshall Rd. Abbotsford, B.C. V2S 5E4 Tel: 604-864-3400 Fax: 604-864-3410	**Burnaby HU** 300-4946 Canada Way Burnaby, B.C. V5G 4H7 Tel: 604-918-7605 Fax: 604-918-7630	**Chilliwack HU** 45470 Menholm Road Chilliwack, B.C. V2P 1M2 Tel: 604-702-4900 Fax: 604-702-4901	**Guildford HU, Surrey** 100-10233 153 Street Surrey, B.C. V3R 0Z7 Tel: 604-587-4750 Fax: 604-587-4777	**Langley HU** Unit 110-6470 201 St Langley B.C. V2Y 2X4 Tel: 604-539-2900 Fax: 604-530-8138	**Maple Ridge HU** 400-22470 Dewdney Trunk Rd Maple Ridge, B.C. V2X 5Z6 Tel: 604-476-7000 Fax: 604-476-7077
Mission HU 7298 Hurd St Mission, B.C. V2V 3H5 Tel: 604-814-5500 Fax: 604-814-5517	**New Westminster HU** 218-610 Sixth Street New Westminster, B.C. V3L 3C2 Tel: 604-777-6740 Fax: 604-525-0878	**North Delta HU** 11245 84 Avenue Delta, B.C. V4C 2L9 Tel: 604-507-5400 Fax: 604-507-4617	**North Surrey HU** 200-10362 King George Boulevard Surrey, B.C. V3T 2W5 Tel: 604-587-7900 Fax: 604-582-4811	**Tri-Cities HU** 200-205 Newport Drive Port Moody, B.C. V3H 5C9 Tel: 604-949-7200 Fax: 604-949-7211	

November 2023

UBC DENTISTRY

THE UNIVERSITY OF BRITISH COLUMBIA

I request that my son/daughter be registered in the Children's Dental Program to be held at UBC. I consent to my child receiving routine dental treatment. **I understand that treatment will be provided by a dental student ("dentist and or dental hygienist in training") under the supervision of a faculty member of UBC Faculty of Dentistry**. However, if the supervising faculty member feels that the treatment is beyond the scope of a dental student, my son/daughter will be referred for treatment to the UBC Graduate Specialty Program in Pediatric Dentistry. Treatment in the graduate program will be provided by a dentist who is taking extra training in children's dentistry. Fees will be charged for treatment in the graduate program and I must arrange transportation.

I understand that treatment may include x-rays, preventive procedures (teeth cleaning, fluoride treatment, dental sealants), silver fillings, silver caps, tooth coloured fillings, extractions (tooth pulling), root canals on baby teeth, and the use of local anaesthetic (freezing).

PLEASE PRINT

Child's Name: **Last name** **First name**		Male ☐ Female ☐	
Address:		City:	Postal Code:
Home Phone:	Email address:	Birthdate: **Year** **Month** **Day**	Age:
Name of parent or guardian: Mother ☐ Father ☐ **Last name** **First name**			
Primary Contact Person:		Primary contact home phone or cell number :	
Family Doctor:	Dr's Phone:	Care Card #:	
Child's School:	Division:	Grade:	
Language Spoken at Home:	Translator:	Translator's Phone Number:	

Please describe your concern: _____

PLEASE COMPLETE THE FOLLOWING MEDICAL HISTORY FOR YOUR CHILD

1. Has your child been a patient in a hospital during the past 2 years? If yes, please explain: Yes ☐ No ☐

2. Has your child been under the care of a physician during the past 2 years for other than regular, routine checkups? If yes, please explain: Yes ☐ No ☐

3. Has your child taken any kind of medicine or drugs during the past year? If yes, please explain: Yes ☐ No ☐

4. Does your child have any allergies? If yes, please explain: Yes ☐ No ☐

5. Does your child have any known heart disease? E.g. Heart murmur If yes, please explain: Yes ☐ No ☐

6. Does your child have chest pain upon exertion? If yes, specify: Yes ☐ No ☐

7. Is your child ever short of breath after mild exercise? If yes, specify: Yes ☐ No ☐

8. Has your child ever been told his/her blood pressure is high or low? If yes, specify: Yes ☐ No ☐

9. Has your child ever been told he/she has kidney disease? If yes, specify: Yes ☐ No ☐

10. Has your child ever had hepatitis, jaundice or liver disease? If yes, specify: Yes ☐ No ☐

11. Does your child have a blood disorder? E.g. anemia If yes, specify: Yes ☐ No ☐

12. Has your child ever bled heavily after having a tooth removed? If yes, specify: Yes ☐ No ☐

13. Does your child bruise or bleed easily? If yes, specify: Yes ☐ No ☐

14. Has your child ever had an unexpected response to medicines or injections? E.g. local anaesthetic (freezing for dental work) If yes, specify: Yes ☐ No ☐

15. Is there anything else you would like us to know about your child? Specify: Yes ☐ No ☐

I declare that the information above is true and accurate to the best of my knowledge and that our family does not have any insurance or other coverage for necessary dental care. I also understand that my child's provincial Care Card number will be used to check his/her eligibility for the Healthy Kids Dental program. My family may be contacted for dental health counselling or for telephone follow-up.

_____ _____

Signature of Parent or Guardian Date

Although UBC will make every effort to complete all treatment your child needs, any treatment <u>not</u> completed is the responsibility of the parent or guardian. Please go to your family dentist for completion of unfinished treatment.

Return Completed – Signed Form To:

Christina Inkster, CDA
North Delta Public Health Unit
11245 84th Ave
Delta, V4C 2L9
Phone: 604 507-5446
Fax: 604 507-4617
Chris.inkster@fraserhealth.ca