Cleft Lip and Palate/Craniofacial Dental Program Referral Form

3945 Matchette Rd.
Windsor, Ontario N9C 4C2
T: 519.252.7281
Toll Free: 1.866.636.6666
F: 519.252.5873
www.jmccentre.ca

☐ **CLP/CDP** ☐ **VPI** **Date:** _____

Name: _____ **Sex:** ☐ M ☐ F

DOB: _____ **Health Card #:** _____

Referred By: _____

Parents/Guardian: _____

Address/Postal Code: _____

_____

Phone (Home): _____ **(Cell):** _____

Reason For Referral/Diagnosis:

Family Doctor: _____

Speech/Language Pathologist: _____

Other Attending Physicians: _____

School (Other Agencies): _____

Specific Concerns:

FOR VPI REFERRALS:

Other Pertinent Information: (e.g. history of nasal regurgitation, etc.)

For Office Use Only

☐ Full Clinic ☐ Screening