Referral form
for professionals

YANG GU BDS, MSc., Dip. OMOP, FRCD (c)

Certified Specialist in Oral Pathology

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Introducing________________________________Gender_________Birthday_________________________

Contact phone (1) ____________________ (2)_________________ E-mail__________________________

Chief complaint:____

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Dental History:____

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Medical History:____

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Your comments:____

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Please attach medical investigations (copy or original) if it is available for you, we will return ASAP.

1. Imaginings or reports: PA, PAN, H&N radiograph, H&N MRI etc.
2. Laboratory test: CBCD exam, chemistry screen, autoimmune profile, hormone panel etc.
3. Biopsy reports or the name of Biopsy Service Center (____________________________________)
4. List of medications or the name of Pharmacy (____)
5. Consultation letters from other professionals

Referred by ____Date_________________________________

Office Phone_____________________ Fax________________ E-mail_______________________________

Mail address ____

Clinic address: 1528 Robie St. Halifax, NS B3H 3E4
Parking: the rear of the building
Phone: 902-221-0081 Fax: 902-425-1551
Practice hours: Friday 8:30 am - 5:30 pm

Mail address: 1645 Oxford St. Halifax. NS B3H 3Z5