Pediatric Cranio-Maxillofacial Surgery Referral Form

Please fax this form to (905) 296-6518, or email to gallegova@hhsc.ca
A standard referral form will also be accepted

Patient Info

Health Card No. _____ VC _____

Patient Name: _____ Gender _____

DOB (DD/MM/YY): _____ Main Tel/Mobile _____ Alt Tel _____

Reason for Referral

□ Cleft Lip/Palate
□ Craniosynostosis/Plagiocephaly
□ Craniofacial Disorder
□ Orthognathic Surgery
□ OSA of Skeletal Origin
□ Other _____
□ Complex Oral Surgery
□ Craniofacial Pathology
□ Facial Trauma
□ TMJ Disease
□ Tongue-Tie/Ankyloglossia

Investigations (please attach results): □ CT □ X-Ray □ MRI □ US

Comments:

Referring Healthcare Professional Info

Name _____

Tel _____ Fax _____ Address _____

City _____ Province _____ Postal Code _____

Outpatient Clinic Location:
Rockwood Oral & Maxillofacial Surgery
623 Upper James St # 101, Hamilton ON L9C 2Y9

Hospital Location:
McMaster Children's Hospital
1200 Main St W, Hamilton ON L8N 3Z5

Tel: (905) 296-6555 | Fax: (905) 296-6518