Oral Dysplasia Program

BC Oral Cancer Prevention Program
2-119, 675 West 10th Avenue
Vancouver, BC V5Z 1L3
T 604.675.8057 | F 604.675.8079 | www.orcanet.ca

For referral of patients with biopsy-proven dysplasia

REFERRING:

DATE OF REFERRAL: _____ **Pathology Report #**_____

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

_____

PERSONAL HEALTH NUMBER: _____

TELEPHONE: (home) _____ (work) _____

REFERRED BY:

FAMILY PHYSICIAN NAME: _____ MSP BILLING NUMBER: _____

ADDRESS: _____

TELEPHONE: (office) _____ FAX: _____

COMMENTS:_____

_____

_____

_____

Location of lesion (please indicate on map):