

Dentist's Referral Form

Children In Need Of Treatment Program (CINOT)

Name of Child: _____

Date of Birth: _____ - _____ - _____ Sex: male female
yy mm dd

Ontario Health Card Number (OHCN): _____

Are you currently receiving:

Ontario Disability Support Program: yes no Ontario Works Assistance: yes no

Parent: (Mother) _____

(Father) _____

Telephone Number: home: _____ work: _____

Address: _____

SCHOOL ATTENDED: _____

Pretreatment Radiographs Enclosed:

yes

no

Dentist's Name: _____ Date: _____

Please Describe Treatment Needed: _____

Date of appointment (if booked): _____