

**NEXT GEN ORAL DYSPLASIA CLINIC**

For referral of patients requiring assessment of suspected or biopsy proven dysplasia:

**UBC Frontier Clinical Research Centre**  
 First Floor JB MacDonald Building  
 Faculty of Dentistry, UBC  
 2199 Wesbrook Mall, Vancouver, BC. V6T 1Z3

**Pacific Oral Health Centre**  
 Suite 300 – 15850 24<sup>th</sup> Ave  
 Surrey, BC  
 V3S 0G1

Please send referral to: Tel: 604 675-8057 • Fax: 604 675-8079 • Email: [orca@bccrc.ca](mailto:orca@bccrc.ca)

REFERRING: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Personal Health Number (required): \_\_\_\_\_

Telephone: (home) \_\_\_\_\_ (cell) \_\_\_\_\_

Patient Email: \_\_\_\_\_

Name of referring office: \_\_\_\_\_

Address: \_\_\_\_\_

Tel: (office) \_\_\_\_\_ (fax) \_\_\_\_\_ Office Email: \_\_\_\_\_

Comments/reason for referral:

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Location of lesion (please indicate):

