Service Request
Children's Oral Health Program

Parent/Guardian Name (Please Print): _____
Last Name / First Name

Mailing Address: _____

Daytime Phone Number: _____ Cell Number: _____

Email address: _____ Preferred method of contact: Phone ☐ Text ☐ Email ☐

Eligible Children Age 17 and Under

Last Name	First Name	Date of Birth (dd/mm/yy)	Last Name	First Name	Date of Birth (dd/mm/yy)
1.			4.		
2.			5.		
3.			6.		

This referral allows the Children's Oral Health Program to contact the parent/guardian to support the family in accessing eligible services offered through Healthy Smiles Ontario and the Children's Oral Health Program.

Parent/Guardian has consented to the referral: Yes ☐ No ☐

Is this an urgent referral: Yes ☐ No ☐

If urgent, reason for referral: _____

Other information: _____

Referred By:

Name (Please Print): _____ Organization: _____
Last Name / First Name

Signature: _____ Date: ___/___/___ Phone # _____ Ext: _____
dd / mm / yy

Office Use Only - Children's Oral Health Program

Referral Outcome: _____

Date: ___/___/___
dd / mm / yy

Personal information on this form is collected under the authority of the Health Protection and Promotion Act, R.S.O. 1990, as amended and in accordance with the Municipal Freedom of Information and Protection of Privacy Act, R.S.O. 1990. This information will be used for screening purposes. Questions regarding the collection of this information should be directed to Privacy Officer, Thunder Bay District Health Unit, 999 Balmoral St., Thunder Bay ON P7B 6E7. Telephone (807) 625-5900.

Children's Oral Health Program
Call 625 5984 or 1 888 294 6630 x5984
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Thunder Bay District Health Unit