Mount Sinai Hospital
Sinai Health System
Joseph & Wolf Lebovic Health Complex

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CLEAR FORM PRINT FORM

ENDODONTIC REFERRAL

REFERRAL INFORMATION

Referral Date:_____ Referral Name:
YYYY / MM / DD

Referral Address (full address required) | Tel #
Fax :

PATIENT INFORMATION

Patient's Name:

Date of Birth: (YYYY / MM / DD) Gender:

Address: Postal Code: Email:

Please check off preferred contact

☐ Tel:(Home) ☐ (Work) ☐ (Cell)

INFORMATION MUST BE COMPLETED IN FULL – PRINT CLEARLY

REASON FOR REFERRAL ☐ Consultation ☐ Patient has discomfort ☐ Endodontic initial treatment

☐ Endodontic re-treatment ☐ Apical surgery

TOOTH STATUS

Q1	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8 Q2
Q4	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8 Q3

☐Recent restoration?_____

☐Endo treatment is initiated ☐Crown/Bridge is cemented temporarily

☐Requires post/which canal

DENTAL RADIOGRAPH ☐ Please take ☐ With Patient ☐ Mailed

Digital xrays (Printed NOT accepted) ☐ Call the Office to discuss the transfer of digital radiographs

Additional Comments: ☐ Patient requires prophylactic medication ☐ Patient requires nitrous oxide

☐ Medications prescribed:

Relevant Dental/Medical History:

Please:

- Fax this referral form to **416-586-4745** Call the office for email information to transfer images – Email is for images only

Appointment Date & Time: _____

Cancellation Policy: This appointment time is reserved for your patient. If unable to attend, our office must be notified at least 3 working days in advance to avoid cancellation charges.