

Please note: This is not an OHIP covered service

FACIAL PAIN UNIT REFERRAL FORM

REFERRAL INFORMATION – COMPLETE ALL INFORMATION TO AVOID A DELAY IN SCHEDULING

Referral Date: _____ Please note referrals are reviewed prior to scheduling appointments.
 YYYY / MM / DD Patients will be contacted via mail in 6 to 8 weeks with their scheduled appointment

Referral Name:	Tel #
	Fax :

Referral Address (full address required)

PATIENT INFORMATION

Patient's Name: _____

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

Address: _____ Postal Code: _____

Please check off preferred contact
 Tel:(Home) (Work) (Cell)

INFORMATION MUST BE COMPLETED IN FULL – PRINT CLEARLY

Dental X-rays: Digital xrays (Printed NOT accepted) Sent on USB Email (call 416-586-8345 for instructions)

Non-Digital X-rays: NO X-rays Sent with Patient Mailed

Additional Reports/Imaging Patient to bring Reports / pertinent radiographs and appliances

Applicances (Patient must bring to initial appointment): Maxillary Night Guard Mandibular Night Guard

Reason for Referral: _____

Relevant Dental History: _____

Relevant Medical History: _____

Current Medications: _____

Please: • Fax this referral form to **416-586-8696** • Call the office for email information to transfer images

Facial Pain Unit to complete **Patient Contacted** (Date:) _____

Appointment Date & Time: _____ **Referral Info Mailed:** _____