

ORAL SURGERY REFERRAL FORM - Please complete the following referral information

 Dr. Brian Rittenberg Tel: 416-586-4800 x7939
 Dr. Eric Ebrahimi Fax Referral to 416-586-4745
 Dr. Geoffrey Duviner Tel: 416-586-8665
 Fax Referral to 416-586-8632

 Dr. Marco Caminiti
 Dr. Kristopher Lee
 Dr. Howard Holmes
 Dr. Joel Davis
 Dr. Karl Cuddy
 Dr. Justin Garbedian
 Tel – 416-586-8491
 Fax Referral to 416-586-4764

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: _____

Please check off preferred contact
 Tel:(Home)

 (Work)

 (Cell)

Health Card Number (OHIP #) _____

Version Code: _____

INFORMATION MUST BE COMPLETED IN FULL – PRINT CLEARLY
Urgency of care: Urgent Routine

RADIOGRAPHS: Please take With Patient Mailed Photos Panorex Ceph Radiograph CBCT

 Digital xrays (Printed NOT accepted) Patient to bring Email (call the office for instructions)

Reason for Referral:
 Extraction

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

55	54	53	52	51	61	62	63	64	65

85	84	83	82	81	71	72	73	74	75

 Implants: Specify area _____

 Pathology: Specify area _____

 Orthognathic Surgery: Skeletal Diagnosis _____

 Trauma Bone Grafting Other: _____

Relevant Medical History: _____

Current Medications: _____

Please:

- Fax this referral form to the practice listed above
- Call the office for email information regarding the transfer images
- **Please inform our office if an interpreter is required.**
- **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.