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

CLEAR FORM PRINT FORM

Dr. David Chvartszaid
Prosthodontist
600 University Ave. Suite #412
Toronto, Ontario M5G 1X5
T: 416-586-4691
F- 416-586-4745

PROSTHODONTIC REFERRAL – Fax referral to 416-586-4745

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)

PLEASE COMPLETE THE FOLLOWING INFORMATION

Urgency of care: ☐ Emergency care ☐ Urgent ☐ Routine

Dental X-rays: ☐ NO X-rays - Please take x-rays ☐ Sent with Patient ☐ Mailed ☐ Ceph Radiograph ☐ CBCT

Digital xrays (Printed NOT accepted) ☐ Mailed/Pt to bring

Reason for Referral:

☐ Prosthodontic Consultation
☐ All-On-Four Planning & Restoration
☐ Full Mouth Rehabilitation
☐ Cosmetic Consultation & Treatment
☐ Implant Pre-Surgical Planning

Additional Information:

Relevant Dental / Medical History:

Current Medications:

Please:
Fax this referral form to **416-586-4745** Call the office for email information to send digital radiographs

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.