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

CLEAR FORM | PRINT FORM

Department of Denitstry
600 University Ave. Suite #412
Toronto, Ontario M5G 1X5
tel: 416-586-5147
Fax Referral to 416-586-5010

REFERRAL INFORMATION –FOR GENERAL DENTISTRY REFERRALS ONLY

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

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

PATIENT INFORMATION

Last Name: First Name: DOB:(YYYY / MM / DD) Gender:

Address: Postal Code: Email:

Contact Person (Guardian)
Include Address Relationship:

Patient compliance: ☐ Good ☐Moderate ☐Poor Interpretor Required (Language)

Please check off preferred contact

☐ Tel:(Home) ☐ (Work) ☐ (Cell)

Mode of Transportation: ☐Ambulance ☐Wheeltrans ☐Stretcher ☐Wheelchair

INFORMATION MUST BE COMPLETED IN FULL – PRINT CLEARLY

REASON FOR REFERRAL: ☐Emergency care ☐ Regular Dental care (medically compromised patients)

DENTAL COMPLAINT & HISTORY:

DENTAL RADIOGRAPHS: ☐ Please take ☐ With Patient ☐ Mailed ☐ Digital xrays (DO NOT SEND PAPER PRINTOUT)

Relevant medical history that warrants treatment in hospital setting**:**

ANTIBIOTIC PROPHYLAXIS: Required for Dental Treatment? ☐YES ☐NO

LAB RESULTS: Recent lab results (eg. Blood sugar; Potassium; CBC; Platelets, etc). ☐YES ☐ NO

ANTICOAGULANTS: ☐ YES ☐ NO Name of Anticoagulant: _____

Recommended INR: _____ Pleae provide last 3 INR results

ALLERGIES ☐ None ☐ Poor Tolerance to Local Anaesthetic ☐ Other medications
If YES be specific

_____

CURRENT MEDICATION(S):

OTHER COMMENTS:

Please:

- Fax this referral form to **416-586-5010**
- **Please inform our office if an interpreter is required.**
- Call the office for email information to transfer images – Email is for images only
- Please note referrals are reviewed prior to scheduling appointments.
- Patients will be contacted in approximately 8 weeks.
- Should there be any emergency, the patient may go to the Emergency Department at Mount Sinai Hospital.