

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) _____ Relationship: _____
Include Address

Patient compliance: Good Moderate Poor Interpreter 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.