

FACIAL PAIN UNIT REFERRAL FORM

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

Referral Date: _____
YYYY / MM / DD

Please note referrals are reviewed prior to scheduling appointments.
Patients will be contacted via mail in 6-8 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: _____ Email: _____

Please check off preferred contact

Tel:(Home) (Work) (Cell)

Health Card Number (OHIP #) _____ Version Code: _____

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:** _____