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

Centre for Advanced Dental Research & Care
Department of Dentistry
600 University Ave. Suite #412
Toronto, Ontario M5G 1X5
T- 416-586-3234 F- 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:

Please check off preferred contact
☐ Tel:(Home) ☐ (Work) ☐ (Cell)

INFORMATION MUST BE COMPLETED IN FULL – PRINT CLEARLY

Urgency of care: ☐ Emergency care ☐ Urgent ☐ Routine

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

☐ Recent full mouth x-rays survey (Date_____________) ☐ Partial x-ray survey (# of films)_____ (Date______________)

☐ Panoramic film

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

Reason for Referral:

☐ Dental Implant Related Problems (soft and/or hard tissue) ☐ Specific area ____________________________________
☐ Mucogingival Condition: Gingival Recession/Attrition
☐ Recurrent Periodontal Abscesses
☐ Continuous Periodontal Bone Loss
☐ Severe/Non-Responsive (refractory) Periodontitis

Patients's chief concern: ☐ Esthetics ☐ Tooth loss ☐ Discomfort ☐ Tooth Mobility ☐ Other

Relevant Dental/Medical History:

Additional Comments:

Please: Fax this referral form to **416-586-4745.** Call the office for email information to transfer 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.