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- 416-586-8632

## 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)

**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 **416-586-8632.** 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.