

Referral - Dental Clinic

Referrals are accepted by fax only, please send to:

Fax: 613-761-5134

REFERRAL INFORMATION

Referral Date (yyyy/mm/dd):	Referring Dentist / Physician:		
Referral Address (full address required):	Telephone:	Fax:	
Email:			

PATIENT INFORMATION

Last Name (print):	First Name (print)	DOB (yyyy/mm/dd):	Gender:
Address:		Postal Code:	
Email:			
Contact Person's Name (Guardian/POA) (print):	Telephone:	Relationship	
Mode of Transportation: <input type="checkbox"/> Ambulance <input type="checkbox"/> ParaTranspo <input type="checkbox"/> Stretcher <input type="checkbox"/> Wheelchair			

INFORMATION MUST BE COMPLETED IN FULL -PRINT CLEARLY

Reason for Referral: Specific concern Comprehensive dental treatment

Dental Complaint & History / Proposed Treatment Plan:

Dental Radiographs: None With Patient Digital X-rays (please send at time of referral to dentalclinic@toh.ca)

Relevant medical history that warrants treatment in hospital setting:

Antibiotic Prophylaxis: Required for Dental Treatment? Yes No

Lab Results: Recent lab results (i.e: HbA1C, CBC, platelets, etc.) Yes No

Anticoagulants: Yes No
 If yes, name of medication: _____ Last INR result: _____

Allergies: Yes No
 If yes, specify: _____

Current Medication(s) (attach list):

Comments: