



124 Edward Street, Toronto, Ontario M5G 1G6 • Phone: 416-864-8002 • Fax: 416-979-4755

REFERRAL TO THE GRADUATE PERIODONTAL CLINIC

Referring dentist: _____ Date: _____

Specialty: _____

Address: _____ City/Postal code: _____

Telephone no.: Bus: _____ Fax: _____ Email: _____

Patient details:

Surname: _____ First name: _____

Date of birth: _____

Address: _____

Telephone no.: Home: _____ Work: _____ Mobile: _____

Radiographs available _____

Examination requested for:

Periodontitis _____

Implants: teeth # _____

Bone Grafting / Sinus Lift _____

Soft Tissue Graft: teeth # _____

Crown Lengthening: teeth # _____

Pre-Prosthetics / Ridge Augmentation _____

Pre-Orthodontics: (Grafting, Frenectomy, Canine exposure)

Patient Background:

Patient requires antibiotic prophylaxis Recall in our office every _____ months

Date of most recent scaling/root planing: _____

Patient's chief concerns: _____

Patient special needs: _____

Relevant medical information: _____

Patient's past dental history synopsis: _____

Other information:

Signature of referring dentist

As a teaching institution:

- We accept referrals that are compatible with our graduate residents' educational program in advanced periodontal care.
- Patients not requiring advanced periodontal care will not be redirected to the Undergraduate Clinics.
- Our patient management office can contact the patient directly to book an initial screening appointment.