UNIVERSITY OF TORONTO
FACULTY OF DENTISTRY

Faculty of Dentistry Surgicentre,
124 Edward St. Toronto, ON M5G 1G6

Referral Form for Paediatric Dental Care under Sedation/General Anaesthesia

Referring Dentist

Address

Phone Fax

Patient Last Name First Name

Patient DOB Patient Weight Dental Benefit Type

Parent/Guardian

Address

Phone 1 Alternate Phone

Dental History/Reason for referral: Radiographs to follow

Pain History of Abscess/facial swelling

Significant Medical History if YES provide details:

Dentist Signature Date

Please fax the completed form (and dental benefit information) to 416-979-4768. Upon receipt of referral our office will contact the patient to book the initial consultation appointment within 3 to 5 business days.