UNIVERSITY OF TORONTO
FACULTY OF DENTISTRY

Telephone: (416) 864-8307
Fax: (416) 979-4769

REFERRAL TO THE GRADUATE ENDODONTIC CLINIC

Please upload referral form along with any x-rays using the Dentdox file transfer system.
The website is https://dentdox.dentistry.utoronto.ca/filedrop/Endo

REFERRING DENTIST DETAILS:

Name:_____ GP:_____ Specialty:_____ Date: _____

Address:_____ City/Postal Code:_____

Telephone:_____ Fax:_____

Email:_____

PATIENT DETAILS:

Surname:_____First names:_____ Date of birth:___/___/_____

Address:_____ City/Postal Code:_____

Telephone:_____ Work:_____ Cell:_____

Email address:_____

Preferred communication method: Letter:☐ Email:☐

REFERRAL DETAILS:

Consultation for tooth/teeth:_____ or Quadrant: _____

Treatment for tooth/teeth:_____

Non-surgical treatment: Initial:_____ Retreatment:_____

Post space required: Yes:☐ No:☐ In which canal(s): _____

Surgical treatment: Apical surgery:☐ Intentional replantation:☐ Other:_____

PATIENT BACKGROUND:

Relevant medical information:_____

Antibiotic prophylaxis required: _____

Chief Concerns:_____

Relevant dental history synopsis:

Discomfort:☐ Pulp exposed:☐ Crown/bridge cementation: Temporary:☐ Permanent:☐

Patient's special needs:_____

Other pertinent information:_____

X _____
Signature of referring dentist

DATED RADIOGRAPHS: ___/___/_____
☐ **WITH PATIENT**
☐ **UPLOADED TO DENTDOX**

As a teaching institution:
- ☐ **We accept referrals that are compatible with our graduate residents' educational program in advanced endodontic care.**
- ☐ **After completion of treatment, patients will be advised to contact your office for further required treatment.**
- ☐ **Our office will contact that patient directly to book a consult appointment.**
- ☐ **For further information, please call (416) 864-8307**