UNIVERSITY OF TORONTO
FACULTY OF DENTISTRY

Telephone: (416) 864-8310
Fax: (416) 979-4769

REFERRAL TO THE GRADUATE PROSTHODONTIC 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/Prostho

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:_____ Cell:_____ Email:_____

Patient's chief concerns: _____

Relevant medical information: _____

Referral for: ☐ **Limited prosthodontic treatment** ☐ **Full mouth prosthodontic treatment**

Reason for referral and your patient's problem:

_____

Patient's past dental history synopsis:

_____

The objectives of the prosthodontics treatment:

_____

Other 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 prosthodontic care.
- If your patient is not compatible with the graduate residents' educational program would you like us to consider your patient for treatment by the University of Toronto Prosthodontic Faculty Staff: ☐ Yes ☐ No
- **Referrals solely for a professional consultation/second opinion will not be accepted.**
- Patients not requiring advanced prosthodontic care will not be redirected to the Undergraduate Clinics.
- Our office will contact the patient directly to book an initial screening appointment.
- **Please be advised/advise your patient that the waitlist is approximately 6-8 months.**
- For further information please call (416) 864-8310.