UNIVERSITY OF TORONTO
FACULTY OF DENTISTRY

Please upload referral form along with any x-rays using the Dentdox file transfer system. The website is https://dentdox.dentistry.utoronto.ca/filedrop/anaesthesia. For further information please call 416-864-8283 (Surgicentre Clinical Reception)

Referral Form for Adult Patient Dentistry Under Intravenous Deep Sedation / General Anaesthesia

Referring dentist details

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

Address: _____

City: _____ Postal Code: _____

Telephone: Bus: _____ Fax: _____

Email: _____

Patient details

Surname: _____ First name: _____

Date of birth: _____

Address: _____

City: _____ Postal Code: _____

Telephone: Home: _____ Bus: _____ Cell: _____

Email: _____

Reasons for Referral:

_____

Patient background:

Patient's chief concerns: _____

_____

Synopsis of dental needs/preliminary diagnoses: _____

_____

Relevant medical information: _____

_____

_____

Patient's special needs (if any): _____

Other pertinent information: _____

_____

Signature of referring dentist

Upon receipt of the referral our office will contact the patient to book the initial consultation appointment.
As a teaching institution:

- We accept referrals that are compatible with our graduate students' educational program in anaesthesia.
- If you wish, after completion of treatment, patients will be advised to contact your office for recall care.

FOR OFFICE USE ONLY

Called: _____ Appointment Date / Time _____

Insurance: _____ Type: _____