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/oralsurgery

Referral Form for the Oral Surgery Clinic

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: ____

Please list the teeth to be extracted or reason 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: ____

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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.
- Panorex must be within 1 year of the referral.
- Please have your patient bring a copy of their Panorex to the appointment
- 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: ____