UNIVERSITY OF TORONTO
FACULTY OF DENTISTRY

Undergraduate Endodontic Treatment – Referral Form

Patient Information

Name: _____

Date of Birth: _____

Address: _____

Telephone: _____

Email: _____

Referring Dentist Information

Name: _____

Address: _____

Telephone: _____

Email: _____

Tooth #: _____

Relevant History:

Radiographs sent with the patient? Yes ◯ No ◯

Date of last check-up: _____

Date of last cleaning: _____

Dentist Signature: _____ Date: _____

Fax or email forms

Fax: 416-979-4767 | email: Rhea.Simon.Gold@dentistry.utoronto.ca | Phone: 416-864-8294

UNIVERSITY OF TORONTO
FACULTY OF DENTISTRY

Notes for referring dentist:

1. The following criteria indicate suitability for an "Undergraduate Endodontic Treatment Only" patient:
    a. Patient is compliant, and able to be managed by undergraduate student
    b. Patient's medical & dental medical conditions allow for dental treatment to be managed by an undergraduate dental student
    c. Stable periodontal condition. Last cleaning must be within 1 year of referral date
    d. Caries activity is under control. Last checkup must be within 1 year of referral date
    e. The tooth is restorable (i.e.. adequate ferrule)
    f. The tooth does not have a crown, inlay or onlay
    g. The tooth has not been endodontically treated before
    h. The tooth is not a 2nd or 3rd molar
    i. Teeth that are unsuitable for undergraduate dental students may be suitable for graduate endodontic students. Please use the referral form for Graduate Endodontics Clinic.

2. No other treatment, including restoration of the endodontically treated tooth, will be arranged for "Undergraduate Endodontic Treatment Only" patients. <u>Patients seeking comprehensive treatment within the Faculty of Dentistry Clinics must enter through the Oral Diagnosis route.</u>

3. The patient will be referred back to you for continuing care.

UNIVERSITY OF TORONTO
FACULTY OF DENTISTRY

CONSENT FOR TREATMENT

I hereby give consent to the Faculty of Dentistry, University of Toronto, to provide basic preliminary dental care, the need for and the cost of which will be explained to me before it is delivered. This may include teeth cleaning, specific investigations, preventive advice and the treatment of decayed or infected teeth. This may also include the taking of records, radiographs and photographs and the administration of necessary anaesthetics and medications. I also understand that this treatment will be done by students only, as part of their learning process.

I hereby give consent for the Faculty of Dentistry, University of Toronto, and its students and residents to use patient treatment records and other patient clinic information, including, for example, diagnostic information, x-rays and photos of treatment outcomes for academic and accreditation purposes such as teaching, publication and examinations, including those undertaken after graduation and/or outside the University of Toronto. Photos of treatment outcomes may show the patient's face.

I have also read and understand the Clinic Policies and Regulations printed on the previous page and agree to abide by them.

As to fees for these services, I agree to make payments as treatment progresses except for those procedures requiring laboratory services. For these services, I shall pay at least one-half the total fee before the treatment is begun and the balance before insertion of the restoration. I am also aware that there may have to be revisions in costs for treatment of long duration. These revisions will be discussed with me before the treatment is begun.

Signature of Patient: _____ Date: _____

(Parent or guardian must sign for dependents or patients under 18 years of age)

Signature of Witness: _____ Date: _____