UNIVERSITY OF TORONTO
FACULTY OF DENTISTRY

Faculty of Dentistry Surgicentre,
124 Edward St. Toronto, ON M5G 1G6

Referral Form for Paediatric Dental Care under Sedation/General Anaesthesia

Referring Dentist

Address

Phone Fax

Patient Last Name First Name

Patient DOB Patient Weight kg Dental Benefit Type HSO

Parent/Guardian

Address

Phone 1 work Alternate Phone cell

Dental History/Reason for referral: Radiographs to follow YES

Pain none reporte History of Abscess/facial swelling NO

Significant Medical History YES if YES provide details:

Dentist Signature Date

Please email anaesthesia@dentistry.utoronto.ca
Upon receipt of referral our office will contact the patient to book the initial consultation