



REFERRAL TO THE GRADUATE ENDODONTIC 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/Endo>

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: _____ Work: _____ Cell: _____
Email address: _____
Preferred communication method: Letter: _____ Email: _____

REFERRAL DETAILS:

Consultation for tooth/teeth: _____ or Quadrant: _____

Treatment for tooth/teeth: _____

Non-surgical treatment: Initial: _____ Retreatment: _____

Post space required: Yes: _____ No: _____ In which canal(s): _____

Surgical treatment: Apical surgery: _____ Intentional replantation: _____ Other: _____

PATIENT BACKGROUND:

Relevant medical information: _____

Antibiotic prophylaxis required: _____

Chief Concerns: _____

Relevant dental history synopsis:

Discomfort: _____ Pulp exposed: _____ Crown/bridge cementation: Temporary: _____ Permanent: _____

Patient's special needs: _____

Other pertinent information: _____

DATED RADIOGRAPHS: ___/___/___

WITH PATIENT

UPLOADED TO DENTDOX

X

Signature of referring dentist

As a teaching institution:

- We accept referrals that are compatible with our graduate residents' educational program in advanced endodontic care.
- After completion of treatment, patients will be advised to contact your office for further required treatment.
- Our office will contact that patient directly to book a consult appointment.
- For further information, please call (416) 864-8307