



REFERRAL TO THE PROSTHODONTICS SPECIALIST CLINIC

Referring dentist: _____ Date: ___ / ___ / _____

Patient details

Surname: _____ First names: _____ Date of birth: ___ / ___ / _____

Address: _____ City/Postal code: _____

Telephone no.: Home: _____ Work: _____ Cell: _____

Patient's Chief Concerns: _____

Any patient special needs: _____

Relevant medical information: _____

Referral for: Limited prosthodontic treatment Full mouth prosthodontic treatment

Reason for referral and your patient's problem: _____

Any attempts to treat your patient's problem in the past? _____

Patient's past dental history synopsis: _____

The objectives of the prosthodontics treatment: _____

Other information: _____

 Signature of referring dentist

Available upon request? (please tick)
 Copies of relevant radiographs?
 Copies of casts?
 Any consultation reports regarding problem?

As a teaching institution:

- we accept referrals that fulfill our graduate residents' learning needs in advanced prosthodontic care
- patients not requiring advanced prosthodontic care **will not** be redirected to the Undergraduate Clinics
- referrals solely for a professional consultation will not be accepted
- our patient management office will contact the patient directly to book an initial screening appointment
- For further contact please call (416) 979-4930 ext. 4424 (Cynthia Enriquez) / ext. 4423 (Heather Hyslop)