Mount Sinai Hospital
Sinai Health System
Joseph & Wolf Lebovic Health Complex

CLEAR FORM | PRINT FORM

Please note: This is not an OHIP covered service

Department of Dentistry
TMD / Facial Pain Clinic
600 University Ave. Suite #412
Toronto, Ontario M5G 1X5
T – 416 586-8345 ext 2
F – 416 586-8696

FACIAL PAIN UNIT REFERRAL FORM

REFERRAL INFORMATION – COMPLETE ALL INFORMATION TO AVOID A DELAY IN SCHEDULING

Referral Date:_____ Please note referrals are reviewed prior to scheduling appointments.
YYYY / MM / DD Patients will be contacted via mail in 6 to 8 weeks with their scheduled appointment

Referral Name:	Tel #
	Fax :

Referral Address (full address required)

PATIENT INFORMATION

Patient's Name:

Date of Birth: (YYYY / MM / DD) Gender:

Address: Postal Code:

Please check off preferred contact
☐ Tel:(Home) ☐ (Work) ☐ (Cell)

INFORMATION MUST BE COMPLETED IN FULL – PRINT CLEARLY

Dental X-rays: Digital xrays (Printed NOT accepted) ☐ Sent on USB ☐ Email (call 416-586-8345 for instructions)

Non-Digital X-rays: ☐ NO X-rays ☐ Sent with Patient ☐ Mailed

Additional Reports/Imaging ☐ Patient to bring Reports / pertinent radiographs and appliances

Applicances (Patient must bring to initial appointment): ☐ Maxillary Night Guard ☐ Mandibular Night Guard

Reason for Referral:

Relevant Dental History:

Relevant Medical History:

Current Medications:

Please: • Fax this referral form to **416-586-8696** • Call the office for email information to transfer images

Facial Pain Unit to complete **Patient Contacted** (Date:)_____

Appointment Date & Time: _____ **Referral Info Mailed:**_____