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

CLEAR FORM PRINT FORM

Department of Dentistry
600 University Ave. Suite #412 Toronto, Ontario M5G 1X5

ORAL & MAXILLOFACIAL SURGERY REFERRAL FORM

Please advise your patient that **OHIP does not cover dental care.** Fees charged are consistent with the ODA Specialist Fee Guide. Payment is required at the time service is provided and we do not accept assignment from insurance companies.

PLEASE PRINT CLEARLY (PDF fillable form preferred)- INCOMPLETE OR ILLEGIBLE FORM WILL BE RETURNED

☐ **Dr. Brian Rittenberg Tel: 416-586-4800 ex 7939 Fax: 416-586-4745** ☐ **Dr. Eric Ebrahimi Tel: 416-586-4800 ex 7939 Fax: 647-789-6702**
☐ **Dr. Karl Cuddy** ☐ **Dr. Justin Garbadian** ☐ **Dr. Joel Davis Tel: 416-586-8491 Fax: 416-586-4764**
☐ **Dr. Maria Franco** ☐ **Dr. Wendall Mascarenhas Tel: 416-586-8491 Fax: 416-586-8696** ☐ **Dr. Geoffrey Duviner Tel: 416-586-8665 Fax: 416-586-8632**

REFERRAL INFORMATION

Referral Date: YYYY/MM/DD Referral Name:

Referral Address (full address required) Tel

Fax :

PATIENT INFORMATION

Patient's Name: Date of Birth: (YYYY / MM / DD)

Address: Gender:

Postal Code:

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

Health Card Number (OHIP #) Version Code:

INFORMATION MUST BE COMPLETED IN FULL – PRINT CLEARLY

Urgency of care: ☐ Urgent ☐ Routine

RADIOGRAPHS: ☐ Please take ☐ With Patient ☐ Mailed ☐ Photos ☐ Panorex ☐ Ceph Radiograph ☐ CBCT

Digital xrays (**Printed NOT accepted**) ☐ Patient to bring ☐ Email (**Referring Office to call for email instructions**)

Reason for Referral:

☐ Extraction

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
55	54	53	52	51	61	62	63	64	65
85	84	83	82	81	71	72	73	74	75
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

☐ Implants: Specify area_____

☐ Pathology: Specify area_____

☐ Orthognathic Surgery: Skeletal Diagnosis_____

☐ Trauma ☐ Bone Grafting ☐ Other:

Relevant Medical History:

Current Medications:

Please:

- Fax this referral form to the practice listed above. Complete form in detail to avoid delay
- Call the office for email information regarding the transfer images
- **Please inform our office if an interpreter is required.**
- **Cancellation Policy:** This appointment time is reserved for your patient. If unable to attend, our office must be notified at least 3 working days in advance to avoid cancellation charges.