Referral Form

Toronto East Maxillofacial Surgery

*Required Fields

Referring Dr.:

Date:

Referring Dr. Phone & Email:

Patient:

First Name:

Last Name:

Mobile:

Work Phone:

Email:

Appointment Date:

Time

- ☐ Extraction
- ☐ Implant
- ☐ Bone Grafting
- ☐ Sinus Lift
- ☐ Pathology
- ☐ Infection
- ☐ Sleep Apnea
- ☐ Exposure of Impacted teeth
- ☐ Orthognathic Surgery
- ☐ Temporary Anchorage Device
- ☐ Temporomandibular Joint Disorders
- ☐ Pediatric Treatment
- ☑ Trauma
- ☐ Other

Please Check Teeth Or Areas To Be Evaluated:

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

○ ○ ○ ○ ○ ○ ○ ○

E D C B A

○ ○ ○ ○ ○

A B C D E

○ ○ ○ ○ ○

E D C B A

○ ○ ○ ○ ○

A B C D E

○ ○ ○ ○ ○

Remarks Or Special Instructions:

Radiographs:

- ☐ Being Mailed
- ☐ Given To Patient
- ☐ Please Take
- ☐ Send Copies Of Radiographs
- ☐ Emailed To admin@temfs.com

IMPORTANT INFORMATION TO READ

- If rescheduling your appointment is necessary, 48 hours notice is required or a fee will be charged for the time reserved.
- If you require sedation, have no food or drink for eight hours prior to your appointment and arrange to have someone accompany you home.
- Minors must be accompanied by a parent or legal guardian.
- Bring this form with you for your appointment.
- Payment for your treatment is required at the time of your appointment via Visa, Mastercard, debit or cash.
- Please wear clothing with short sleeves.
- For patients wearing contact lenses, please bring your carrying case.