LESLIEVILLE PROSTHODONTICS

A Family Dental and Specialty Practice

FROM:

We are located at 1003 Queen Street East,
Toronto, Ontario M4M 1K3
Telephone: (416) 465-7767

WE ARE REFERRING:			
Patient Name:			
Birthdate:		Patient Telephone:	
Address:			
Guardian Name:		Guardian Telephone:	

REASON FOR REFERRAL:

☐ CONSULTATION REGARDING: _____

☐ TREATMENT (as requested):
(Please provide specialist with appropriate details of problem; i.e. urgency, areas of concern, using F.D.I. tooth numbering system.)

(Indicate any special factors – either dental or medical – such as known allergies and specific medical problems relevant to diagnosis and treatment.)

☐ Please call the patient.
☐ Patient will call.
☐ An appointment has been made.

☐ Radiographs enclosed.
☐ Please return radiographs after use.
☐ Notify on completion.
☐ Other records available.

☐ Please report – written
☐ Please report – by phone
☐ Post-referral maintenance:
  ☐ By specialist
  ☐ In this office
  ☐ To be discussed

SIGNED: _____ **DATE:** _____