1 OAK DENTAL
TORONTO

REFERRAL FORM

Pediatric Dentistry • Sleep Dentistry
IV Sedation • Deep Sedation • General Anesthesia

Dr. Ammar Taimish
Practice limited to Oral Surgery and Implant Dentistry
General Dentist

Dr. Alice Dong
Pediatric Dentist

Dr. Zakir Esufali, MD
Anaesthesiologist

REFERRING DOCTOR INFORMATION

Name of Referring Doctor: _____ Email: _____

Office: _____ Phone #: _____

Fax / email for report: _____ Date of Referral: _____ / _____ / _____

PATIENT INFORMATION

First Name: _____ Last Name: _____

Mobile Phone #: _____ Date of Birth: _____ / _____ / _____

Email: _____ Insurance (if known): _____

Radiographs: ☐ Emailed ☐ Please take ☐ Given to patient

TEETH INVOLVED (please circle — FDI numbering, adult and primary teeth)

	18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
				55	54	53	52	51	61	62	63	64	65			
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				85	84	83	82	81	71	72	73	74	75			
	48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38

REFERRAL TYPE (please select all that apply)

Pediatrics

- ☐ Comprehensive treatment
- ☐ Specific treatment _____
- ☐ Emergency treatment
- ☐ Sedation

Patient age: _____

Sleep Dentistry

- ☐ Comprehensive treatment
- ☐ Specific treatment _____
- ☐ Emergency treatment
- ☐ General anesthesia

SEDATION / ANESTHESIA

☐ Local anesthetic only ☐ IV sedation ☐ Deep sedation ☐ General anesthesia ☐ Please discuss with patient

SPECIAL INSTRUCTIONS

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