1 OAK DENTAL
TORONTO

REFERRAL FORM

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

Dr. Zakir Esufali, MD
Anaesthesiologist

Dental Implants • All-on-X • Extractions & Impacted Teeth • Orthodontic Surgical Exposure
IV Sedation • Deep Sedation • General Anesthesia • CBCT Imaging

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)

R	18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	L
	48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	

REFERRAL TYPE (please select all that apply)

Oral Surgery

- ☐ Extraction
- ☐ Impacted / wisdom teeth
- ☐ Orthodontic surgical exposure
- ☐ Other: _____

Implant Dentistry

- ☐ Dental implants
- ☐ Implants for overdenture
- ☐ All-on-X: surgical phase only
- ☐ All-on-X: surgical + prosthetic

SEDATION / ANESTHESIA

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

SPECIAL INSTRUCTIONS

_____

_____

Email this form to **info@1oakdental.ca**
Urgent cases: **416-214-0003**

New referrals are seen within a few days.
Your patient returns to you with a written report.