ST. JOSEPH'S UNITY HEALTH TORONTO

Ambulatory Care Clinic
Dental Referral Form

30 The Queensway, Toronto, ON M6R 1B5
Booking Office: (416) 530-6043 Fax: (416) 530-6050

For Hospital Use

PATIENT INFORMATION

Last Name	Given Names	Date of Birth (YYYY/MM/DD)

Address	OHIP #

City	Postal Code	Telephone No

Language Spoken _____

☐ Patient has been advised that an adult English speaking translator is required to come with patient.

CONTACT INFORMATION

Name:	Relationship to Patient	Telephone No

REFERRAL INFORMATION

Reason for Referral

Dental Complaint and History

Medical History:
☐ Detailed Below ☐ Attached

Medications:
☐ As Listed Below ☐ Attached

Radiographs:

☐ Duplicates given to patient to bring to appointment

☐ Duplicates sent directly to Dr. Tershakowec at:
5 Old Mill Drive, Toronto, ON M6S 4J7

Referring Dentist's Name:

Date of Referral (YYYY/MM/DD)

Clinic Stamp/Address