TORONTO DENTAL SPECIALISTS

Referral Form

Prosthodontist ☐ Dr. Mark Lin ☐ Dr. Bo Huang ☐ Dr. Max Li
Periodontist ☐ Dr. Jae W. Chang
Endodontist ☐ Dr. Alice F.C. Li
Dental Anesthesiologist ☐ Dr. Stephen Ing

PATIENT INFORMATION

First Name: _____

Last Name: _____ Title: _____

Date of Birth: _____DD/MM/YY

Address: _____

_____

Tel: _____

Email: _____

REFERRING DOCTOR INFORMATION

First Name: _____

Last Name: _____

Practice: _____

Address: _____

_____

Tel: _____

Email: _____

Preferred Languages: ☐ English ☐ Cantonese ☐ Mandarin Others: _____

REASON(S) FOR REFERRAL, CHECK ALL THAT APPLIES

Prosthodontic

- ☐ Dental Implant (s)
- ☐ Implant Complications
- ☐ Full Mouth Reconstruction
- ☐ Fixed Prosthodontics
- ☐ Removable Prosthodontics
- ☐ Bone Grafting/Augmentations
- ☐ Cosmetic/Aesthetic Dentistry
- ☐ Second Opinion
- ☐ Others (please specify in notes)

Periodontic

- ☐ Periodontal Evaluation
- ☐ Deep Pockets/Furcation Involvement
- ☐ Crown Lengthening
- ☐ Recession/Soft tissue grafting
- ☐ Specific Surgical Exam
- ☐ Unerupted Tooth Exposure
- ☐ Orthodontic Co-therapy
- ☐ Biopsy/Oral Lesion Evaluation
- ☐ Others (please specify in notes)

Endodontic

- ☐ Consultation Only
- ☐ Root Canal Treatment
- ☐ Retreatment
- ☐ Apical Surgery
- ☐ Post Space Preparation
- ☐ Restore Endodontic Access
- ☐ Tooth Bleaching
- ☐ Other (Please specify in notes)

CBCT

- ☐ Dental Implants Evaluation
- ☐ Pathology
- ☐ Preferred Implant System

_____

- ☐ CBCT _____
- ☐ Pan

Radiographic Guide Provided ☐ Yes ☐ No

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

Previous Radiographs

☐ Sent with patient ☐ Emailed

Date of x-rays: _____

NOTES:

TORONTO DENTAL SPECIALISTS
88 Finch Ave East, North York, Ontario M2N 4R5
Tel: 416-221-2950 / 1-888-7-DRLIN-8
Fax: 416-221-6396
smile@oralhealth4life.net
www.oralhealth4life.net

OUR TEAM

Dr. Mark Lin
Prosthodontist

Dr. Bo Huang
Prosthodontist

Dr. Max Li
Prosthodontist

Dr. Stephen Ing
Anesthesiologist

Dr. Alice F.C. Li
Endodontist

Dr. Jae W. Chang
Periodontist

Please be advised that the appointment time has been exclusively scheduled for you. We respectfully request three business days' notice if you must reschedule your appointment. We do not accept cancellations via email or phone message. Please call to reschedule your appointment accordingly. Otherwise, a cancellation fee will be charged for missed appointments or short notice cancellations.

Please bring or email in advance the following to your scheduled appointment:

☐ This referral form
☐ Any radiograph(s) given to you by your own dentist
☐ Any other relevant/Important information of history regarding your case

Appointment Date: _____ Time: _____

Free parking is available in the back of the building
Close to Finch Subway station

CONSULTATION FEE	
45-minute appointment	$200
CBCT	
One Quadrant	$250
One Arch	$375
Two Arches	$420

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