

**BRING THIS REFERRAL TO YOUR APPOINTMENT,  
FULLY COMPLETED BY YOUR DENTIST**



# Metropolitan

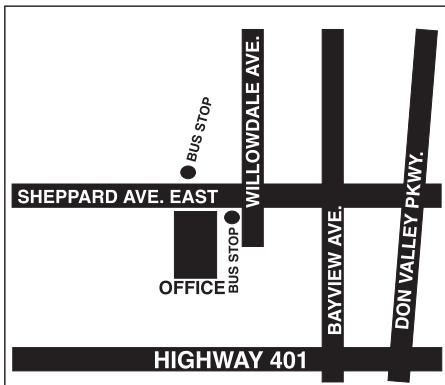
Oral and Maxillofacial Surgery Centre

**JEFFREY FARBER, B.Sc., D.D.S., F.R.C.D.(C).**  
**GEOFFREY A. DUVINER, HON. B.Sc., D.D.S., F.R.C.D.(C)**

ASSOCIATE:

**B. CEM SENER, D.D.S., Ph.D.** (GENERAL DENTIST WITH PRACTICE LIMITED TO ORAL SURGERY)

143 SHEPPARD AVENUE EAST  
TORONTO, ONTARIO M2N 3A6  
TEL: (416) 223-7292  
FAX: (416) 512-6616  
EMAIL: 143@metropolitanoms.com



#### OFFICE HOURS

Monday to Thursday, 8:00 am - 5:00 pm  
Friday, 8:00 am - 3:00 pm  
After Hours Emergency Tel (647) 417-8911

#### PARKING

FREE parking behind office.

#### YONGE/SHEPPARD SUBWAY STATION

Take the Sheppard Avenue East (85) bus to Dudley Avenue, scheduled to run every 20 minutes. Continue to walk east on the south side.

Walking east on Sheppard Avenue may take 15-20 minutes.

815 DANFORTH AVENUE, SUITE 401  
TORONTO, ONTARIO M4J 1L2  
TEL: (416) 922-3273  
FAX: (416) 922-1835  
EMAIL: 815@metropolitanoms.com



#### OFFICE HOURS

Monday to Thursday, 8:00 am - 5:00 pm  
Friday, 8:00 am - 12 pm  
After Hours Emergency Tel (647) 417-8911

#### PARKING

Green P Parking on Eaton Ave (See Map)

#### DONLANDS SUBWAY STATION

Take Donlands Ave. exit. Walk up the stairs to street level, turn right and walk south to Danforth Avenue. Turn right at Danforth, walking west just past Jones Ave. to #815 (south side)

#### PAPE SUBWAY STATION

Take Pape St. exit. Walk up the stairs to street level. Turn left and walk south towards Danforth Avenue. Turn left at Danforth, heading East to #815 (south side).

## INSTRUCTIONS FOR PATIENTS: GIVE THIS COMPLETED REFERRAL TO RECEPTION UPON ARRIVAL

- ▶ **Bring:** I.D. (Health Card or Government issued I.D.), a list of your current medications, medical history info, reading glasses if needed and a translator, if necessary.
- ▶ If you are having surgery during your visit, do not take any recreational drugs within 48 hours prior to your appointment.
- ▶ Late arrivals may be re-scheduled. Cancellations require **two** full business days' notice.

|                     |             |
|---------------------|-------------|
| Patient's Name      | Referred By |
| Patient's Contact # | Office #    |

Patient's Email Address \_\_\_\_\_

Date of Appt. \_\_\_\_\_  143 Sheppard Office  
 815 Danforth Office

**Reason for Referral**

- |   |   |
|---|---|
| Removal of Teeth ..... <input type="checkbox"/>     | T.M.D./Facial Pain ..... <input type="checkbox"/> |
| Orthognathic Surgery ..... <input type="checkbox"/> | Pathology ..... <input type="checkbox"/>          |
| Implants ..... <input type="checkbox"/>             | Bone Grafting ..... <input type="checkbox"/>      |
| Other .....   |   |

Radiographs:  Film - sent with Patient  
 Digital - Must be e-mailed, with name + date attached

Remarks: .....

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|              |          |   |   |   |   |   |   |   |   |   |   |   |   |   |             |   |   |          |
|--------------|----------|---|---|---|---|---|---|---|---|---|---|---|---|---|-------------|---|---|----------|
| <b>Right</b> | <b>1</b> |   | E | D | C | B | A |   | A | B | C | D | E |   | <b>Left</b> |   |   |          |
|              |          | 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1 | 1 | 2 | 3 | 4 | 5 | 6           | 7 | 8 | <b>2</b> |
|              |          | 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1 | 1 | 2 | 3 | 4 | 5 | 6           | 7 | 8 |          |
| <b>4</b>     |          |   |   |   | E | D | C | B | A | A | B | C | D | E |             |   |   | <b>3</b> |

\_\_\_\_\_  
 Signature of Referring Doctor Date