COMMUNITY MATTERS TORONTO
neighbours helping neighbours

Referral to Dental Center from Community Matters Toronto

Date	CMT Staff	Phone

Basic Information

First Name	Last Name
Ok to leave a message? Y N	
Tel	Alternate Tel
Email	Preferred Language of Service
	Special Instructions for Calling
Address	

Reason for Referral

CMT Screening Results:_____

Primary Reason for Referral:

_____

Related Health Issues:

Consent I have informed the person that: Yes☐ No ☐

1. These services are not covered by OHIP.
2. The Dental Center will provide X ray and cleaning services at 50% of the recommended current Ontario Dental Association Fee Guide, and treatment services at 25% of the current Ontario Dental Association Fee Guide

We need your permission to share this information with our staff and/or the Dental Center. Your information is private, and unless required by law, we will not share your information to anyone else without your permission. Do you give consent to this?

_____
Signature

With your permission, I will ask Dental Center to contact you to arrange the service(s) you need.
Consent? (Y/N)

Dental Center
Contact Information

Date called	Time called	Appointment confirmed: Date and Time- _____
Comments		

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