

**ONTARIO ASSOCIATION OF CRANIOFACIAL TRAUMA SURGEONS (OACTS)
REFERRAL FORM**

**DR. TARA LYNN TESHIMA
MD MSC FRCSC
PLASTIC AND RECONSTRUCTIVE SURGEON
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MARKHAM, ONTARIO, L6B 1A1
PHONE: 905-472-7353
FAX: 905-472-7603**

PATIENT ID STICKER

Patient's Contact Phone Number: _____

Direct referrals to Dr. Teshima should be made for non-urgent facial fractures (see list below). For any other facial fractures requiring urgent assessment or management (i.e. intra-cranial injury, airway compromise, retrobulbar hematoma, orbital muscle entrapment) please call CritiCall at **1-800-668-4357**

DATE OF REFERRAL: ___/___/___ **DATE OF INJURY:** ___/___/___

REASON FOR REFERRAL: _____

DIAGNOSIS:

- | | | |
|--|--|---|
| <input type="checkbox"/> Nasal bone fracture | <input type="checkbox"/> Zygoma fracture | <input type="checkbox"/> Orbital Fracture |
| <input type="checkbox"/> Maxilla fracture | <input type="checkbox"/> Mandible Fracture | <input type="checkbox"/> Frontal Sinus Fracture |
| <input type="checkbox"/> Other: _____ | | |

DIAGNOSTIC IMAGING PERFORMED: Plain Films CT Scan (Facial Views)

LOCATION OF IMAGING: _____

C-SPINES CLEARED: Yes No **OPHTHAMOLOGY CONSULT:** Yes No

REFERRING PHYSICIAN INFORMATION:

Name: _____ Billing #: _____

Phone: _____ Fax: _____ email: _____

Signature of Referring Physician: _____

Please Fax all referral forms to Fax number listed above and send all relevant diagnostic imaging with the patient (CT facial bones). All trauma patients should have their C-spines cleared and a referral to Ophthalmology for all orbital trauma.