44 | THE PRIVATE DENTAL CENTRE

TREATMENT REFERRAL FORM

www.44derngate.co.uk

REFERRING DENTIST

Name:

Practice:

Address:

Postcode:

Phone:

Fax:

Mobile:

E-mail:

PATIENT DETAILS

Name:

Practice:

Address:

Postcode:

Phone:

Fax:

Mobile:

E-mail:

Referral for:

	Urgent	
Endodontics	Yes	No
Implants	Yes	No
Peri-Implantitis	Yes	No
Sedation	Yes	No
Periodontics	Yes	No
Prosthodontics	Yes	No
Restorative Dentistry	Yes	No
Surgical Dentistry	Yes	No
Other (Please State)	Yes	No

Referral details

Purpose of referral:

Patients main complaint:

HISTORY

Oral condition:

Excellent Above average Below average Poor

Periodontal state:

Excellent Above average Below average Poor

Missing teeth:

UR8 UR7 UR6 UR5 UR4 UR3 UR2 UR1 - UL1 UL2 UL3 UL4 UL5 UL6 UL7 UL8

LR8 LR7 LR6 LR5 LR4 LR3 LR2 LR1 - LL1 LL2 LL3 LL4 LL5 LL6 LL7 LL8

Pain: 0 + ++ +++ **Swelling:** 0 + ++ +++

Documents	Enclosed	In the post	To return?
Patient records			
Consent form			
Study models			
Radiographs			
Intra-oral:			
Panoral:			
Dental history			

Other relevant information:

Signature:

Date: