

SPECIALIST REFERRAL REQUEST

Referral for:	Urgent	Non-Urgent
Implant Dentistry	<input type="checkbox"/>	<input type="checkbox"/>
Prosthodontics	<input type="checkbox"/>	<input type="checkbox"/>
Endodontics	<input type="checkbox"/>	<input type="checkbox"/>
Extractions	<input type="checkbox"/>	<input type="checkbox"/>

Urgent- to be seen immediately

Non-urgent – to be seen within 3 weeks

Referral Status

- Opinion & Plan only
- Opinion & Treatment Only
- Treatment and on-going Maintenance

Referring Practitioner

Name:

Practice:

Address:

Postcode:

Phone:

Fax:

Mobile:

E-Mail

Patient Details

First Name:

Title:

Last Name:

D.O.B

Address:

Postcode:

Phone:

Fax:

Mobile:

E-Mail

Referral Details

Patients Main Complaint

Relevant Medical and Dental History

Oral Condition

Above Average Average Below Average

Periodontal state:

Above Average Average Below Average

Other Relevant Information