QUICK REFERRAL

Call us directly on 01494 854053

We'll do the rest

DENTAL & IMPLANT CENTRE

PATIENT REFERRAL FORM:

Date of Referral: _____ Date of Birth: _____

Mr ☐ Mrs ☐ Ms ☐ Other ☐ _____ Home Tel: _____

Surname: _____ Work Tel: _____

Forename(s): _____ Mobile: _____

Address: _____ Email: _____

_____ Post Code: _____ Best Time to Call: _____

Referral For: Advice ☐ Treatment ☐

Please indicate type of referral:

Implants ☐ Prosthodontics ☐ IV Sedation ☐

X-Rays Enclosed: Yes ☐ No ☐ Study Cases Enclosed: Yes ☐ No ☐

REFERRING PRACTITIONER DETAILS:

Mr ☐ Mrs ☐ Ms ☐ Other ☐ _____ Address: _____

First Name: _____ Home Tel: _____

Surname: _____ City/Town: _____

Email: _____ Tel: _____

Signature: _____ Mobile: _____

REFERRAL & MEDICAL HISTORY INFORMATION:

_____

_____

_____

All patients who have been referred to the practice will be returned back to you once treatment has been completed (unless otherwise required). It is our policy to keep you informed at the beginning and end of treatment. If the patient has only been referred for assessment or treatment planning, a letter will be sent bck as soon as possible.

Please feel free to contact the practice at any time if you have any queries, or if you would like to discuss any aspect of the treatment with the specialist.

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