OXFORD HOUSE
Dental Practice
The Referral Centre

TREATMENT REFERRAL FORM

www.mkdentist.co.uk/treatment-referral-form

REFERRING DENTIST DETAILS

Name of Practitioner:

Practice Name:

Address:

Postcode:

Practice Phone Number:

Mobile:

Email:

PATIENT DETAILS

Patient First Name:

Patient Surname:

Patient Address:

Postcode:

Date of Birth:

Mobile:

Email:

Referral for

☐ Endodontics	Yes ☐ No ☐
☐ Prosthodontics	Yes ☐ No ☐
☐ Oral Surgery	Yes ☐ No ☐
☐ Periodontics	Yes ☐ No ☐
☐ Dental Implants	Yes ☐ No ☐
☐ IV Sedation	Yes ☐ No ☐
☐ Other (Please State)	Yes ☐ No ☐
☐ Any Treatment to be carried out by yourself? eg. Restoring Implants	Yes ☐ No ☐

Other details:

Purpose of Referral:

Patients Main Complaint:

History

Oral Condition

Excellent ☐ Above Average ☐ Average ☐ Below Average ☐ Poor ☐

Periodontal State

Excellent ☐ Above Average ☐ Average ☐ Below Average ☐ Poor ☐

Pain

Nil ☐ Slight ☐ Moderate ☐ Severe ☐

Swelling

Nil ☐ Slight ☐ Moderate ☐ Severe ☐

Other relevant information:

Submitted by:

Submitted date:

☐ Please tick to be kept informed of lectures, events and allow us to email articles.
If you prefer to use a different email address please input here: _____