TREATMENT REFERRAL FORM

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

Oxford House
THE REFERRAL CENTRE

REFERRING DENTIST DETAILS

Name of Practitioner | Date

Practice Name

Practice Address

Postcode

Practice Phone Number | Mobile

Email

PATIENT DETAILS

Patient First Name | Surname

Patient Address

Postcode

Date of Birth

Mobile | Email

REFERRAL FOR (Please tick all relevant boxes)

REFERRAL FOR

- ◯ Endodontics
- ◯ Oral Surgery
- ◯ Dental Implants
- ◯ Periodontics IV
- ◯ Sedation
- ◯ Other (please state)
- ◯ Any treatments to be carried our by yourself? e.g. Restoring Dental Implants

PURPOSE OF REFERRAL

OTHER DETAILS/RELEVANT INFO

HISTORY

Oral Condition

◯ Excellent ◯ Above Average ◯ Average ◯ Below Average ◯ Poor

Periodontal State

◯ Excellent ◯ Above Average ◯ Average ◯ Below Average ◯ Poor

PATIENTS MAIN COMPLAINT

PAIN

◯ Nil ◯ Slight ◯ Moderate ◯ Severe

SWELLING

◯ Nil ◯ Slight ◯ Moderate ◯ Severe

SUBMITTED BY

Name | Date

Email

◯ Please tick to consent to be kept informed of lectures, events and allow us to email articles.