Patient referral form

rosebank dental practice

Patient Details

Name:_____

Date of birth:_____

Address:_____

_____

_____

Postcode:_____

Telephone:_____

Email:_____

Referring Dentist

Name:_____

Practice Name:_____

Address:_____

_____

_____

Postcode:_____

Telephone:_____

Email:_____

Referral type:

☐ Endodontics ☐ Prosthodontics ☐ Orthodontics ☐ Periodontics ☐ Dental Implants

All-on-4:

☐ Upper ☐ Lower ☐ Both ☐ Zygoma

General dental implants:

☐ Single tooth ☐ Multiple teeth ☐ Overdenture ☐ Sinus Grafting

Request is for:

☐ Implant placement only ☐ Implant placement and restoration

Would you like to observe/assist with the procedure:

☐ Yes ☐ No

Treatment Required

Relevant medical history

Diagnostic Aids

In order to minimise unnecessary exposure, please indicate which images you are sending with the referral

☐ OPG ☐ PA's ☐ Other radiographs ☐ CT or Clinical Photographs

☐ For more complex cases, please indicate that study models will accompany the patient for the initial consultation

Your referrals are important to us and we will not approach or accept your patient for non-referred treatment.

Signature _____ **Date**_____

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