Surgical Referral Form

dental referral

REFERRING DENTIST

Name: _____ Tel: _____

Address: _____ Fax: _____

_____ Email: _____

Post code: _____ Date: ____ / ____ / ____

PATIENT DETAILS

Name: _____ Home Tel: _____

Address: _____ Work: _____

_____ Mob: _____

Post code: _____ D.O.B.: ____ / ____ / ____

Is this referral urgent? ☐ Yes ☐ No

RELEVANT MEDICAL HISTORY (Any additional comments about this referral)

TYPE OF REFERRAL (Please tick)

☐ Patient new to your practice ☐ Regular Attender

REASON FOR REFERRAL (Please tick/specify)

☐ Current/previous history of infection

☐ Unrestorable caries

☐ Non-treatable pulpal and/or periapical pathology

☐ Periodontal disease

☐ Orthodontic reasons (please include copy of orthodontic letter)

☐ Facilitation of restorative treatment including provision of prosthesis

☐ Internal/external resorption of tooth or adjacent teeth

☐ Pain directly related to third mollar including pericoronitis

☐ Fracture of tooth

☐ Disease of follicle including suspected cyst

Any other (please specify) _____

_____

TOOTH NOTATION

RIGHT								LEFT							
☐ 18	☐ 17	☐ 16	☐ 15	☐ 14	☐ 13	☐ 12	☐ 11	☐ 21	☐ 22	☐ 23	☐ 24	☐ 25	☐ 26	☐ 27	☐ 28
☐ 48	☐ 47	☐ 46	☐ 45	☐ 44	☐ 43	☐ 42	☐ 41	☐ 31	☐ 32	☐ 33	☐ 34	☐ 35	☐ 36	☐ 37	☐ 38

GENERAL

Has the patient been made aware of the level of investment that may be required? ☐ Yes ☐ No

Please be assured that we will neither approach nor accept your patient for non-referred treatment.