



REFERRING DENTIST

NAME	_____	DATE	_____
ADDRESS	_____	TEL	_____
	_____	FAX	_____
	_____ POST CODE _____	EMAIL	_____

PATIENT DETAILS

NAME	_____	HOME	_____
ADDRESS	_____	WORK	_____
	_____	MOB	_____
	_____ POST CODE _____	DOB	_____

RELEVANT MEDICAL HISTORY

PLEASE INCLUDE ANY RADIOGRAPHS WHICH MAY HELP IN EVALUATING THE PATIENT. WE WILL RETURN THEM TO YOU AFTER USE.

TYPE OF REFERRAL (PLEASE TICK)

- PATIENT NEW TO YOUR PRACTICE
- REGULAR ATTENDER

REASON FOR REFERRAL

- CONSULTATION
- INITIAL ROOT TREATMENT
- RE-ROOT TREATMENT
- POST REMOVAL
- TRAUMA
- PERFORATION/ROOT RESORPTION TREATMENT
- INSTRUMENT REMOVAL
- POST & CORE BUILD-UP
- ENDODONTIC SURGERY (CONSULTATION REQUIRED)

- OTHER (PLEASE SPECIFY) _____

TOOTH NOTATION

SEDATION REQUIRED (ORAL / IV) Yes No

