

MOUTH MATTERS REFERRAL PRACTICE: INDEPENDENT DENTAL HYGIENIST SERVICES

REBEKAH HALSTED, BSC;
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REFERRING DENTIST

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

PATIENT DETAILS

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

RELEVANT MEDICAL HISTORY

- BASIC PERIODONTAL EXAMINATION (BPE) (CODE 4 REQUIRES FULL PERIODONTAL ASSESSMENT)
- FULL PERIODONTAL ASSESSMENT (IF NECESSARY, PLEASE REFER TO PERIODONTAL SPECIALIST)
- SCALE AND POLISH WITH O.H.I.
- NON-SURGICAL PERIODONTAL THERAPY (DETOX THERAPY) PLEASE SPECIFY AREA _____
- ROOT SURFACE INSTRUMENTATION - PLEASE SPECIFY AREA _____
- DESENTIZATION - PLEASE SPECIFY AREA _____
- FLOURIDE APPLICATION - PLEASE SPECIFY AREA _____
FLOURIDE TOOTHPASTE
0.62% DURAPHAT 2800
1.1% DURAPHAT 5000
- SUPPORTIVE PERIODONTAL THERAPY
1 YEAR
2 YEARS
3 YEARS
- OTHER REQUIREMENTS - PLEASE SPECIFY AREA _____
- PLEASE X-RAY AFFECTED AREA _____

UNDER CURRENT REGUALTION, REFERRALS TO A HYGIENIST CAN BE VALID FOR 1-3 YEARS. PLEASE INDICATE BY SIGNING BELOW THAT YOU ARE HAPPY FOR THE ABOVE TREATMENT TO BE CARRIED OUT

WHEN WOULD YOU LIKE THE PATIENT TO BE SEEN AGAIN BY YOU?

SIGNED (REFERRING DENTIST)

