Mouth Matters Referral Practice: Independent Dental Hygienist Services

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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)

_____ _____

5 York Street, Chester CH1 3LR • **Tel:** 01244 343353 • **Fax:** 01244 343363
contact@mouthmatters.co.uk • www.mouthmatters.co.uk
Further referral forms can be downloaded from our website