Mouth Matters Referral Practice:
Prosthodontic Referral

Dr Paul Tipton BDS M.Sc. DGDP
GDC Registered Specialist in Prosthodontics

Referring Dentist

Name _____ Date _____
Address _____ Tel _____
_____ Fax _____
_____ Post code _____ email _____

Patient Details

Name _____ Home _____
Address _____ Work _____
_____ Mob _____
_____ DOB _____
_____ Post code _____ Email _____

Relevant Medical History

_____

_____

Please include any radiographs and models 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

Prosthodontics

☐ Consultation
☐ Cosmetic Dentistry
☐ Full Mouth Reconstruction
☐ Implant Prosthetics
☐ Treatment of Wear
☐ Implant Retained Dentures
☐ Full Dentures
☐ Smile Makeover
☐ Dental Face Lift
☐ Gum Lift
☐ Other _____

Isolated Procedure (please specify)

_____

_____

Sedation required (Oral / IV) ☐ Yes ☐ No

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