Referralform

UK Dental Specialists
at Chiswell Green

Firstnameofpatient

Surnameofpatient

Gender of patient

☐ Male ☐ Female

Dateofbirthofpatient

Address

Patientcontactnumber

Nameofreferringdentist

Referringdentist

Practicephonenumber

Practice e-mailaddress

Datethispatientregistered

Patientsdentalplan

☐ UR8	☐ UR7	☐ UR6	☐ UR5	☐ UR4	☐ UR3	☐ UR2	☐ UR1
☐ UL1	☐ UL2	☐ UL3	☐ UL4	☐ UL5	☐ UL6	☐ UL7	☐ UL8
☐ LR8	☐ LR7	☐ LR6	☐ LR5	☐ LR4	☐ LR3	☐ LR2	☐ LR1
☐ LL1	☐ LL2	☐ LL3	☐ LL4	☐ LL5	☐ LL6	☐ LL7	☐ LL8

Referralform

UK Dental Specialists
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Treatmentrequired

Typeof care requested

Opinionony Examinationandtreatment Preparepostspace

Stateofcondition(tickallthatapply)

Swelling
Endodontic treatment started
Pulpexposedandbleeding
Elective endodontic treatment
Dressingandtemporaryfillinginserted
Permanent bridge/crown is cemented
Tooth opening for drainage
Patient has discomfort
Patient is likely to require sedation

Ifyourconditionisnotlistedabove,pleasegivedetailsbelow

Isthe condition urgent?

Yes No

Pleasegiveanymoredetails

Dentaltreatmentgiventodate

Relevantmedicalhistory

Permissiontoperformfurthertreatmentifrequired?

Yes No

Pleasegiveanymoredetails

Haveradiographsbeentaken?

Yes No

Willradiographsbesentseparately(byemailorpost)?

Yes No

Doyouwishradiographstobereturned?

Yes No