PATIENT REFERRAL

PLEASE PLACE A TICK IN THE BOX OF THE REFERRAL TYPE YOU REQUIRE

☐ IMPLANTS ☐ PERIODONTAL ☐ ENDODONTICS

☐ ORTHODONTICS ☐ ORAL SURGEY ☐ RESTORATIVE

BDS BIRMINGHAM DENTAL SPECIALISTS

PATIENT DETAILS:

TITLE:..... DATE OF BIRTH.....

FIRST NAME:..... SURNAME.....

ADDRESS.....

.....

POST CODE..... ... EMAIL.....

TELEPHONE..... MOBILE.....

REFERRAL DETAILS:

REASON FOR REFERRAL.....

.....

.....

PATIENTS'S COMPLAINT.....

.....

.....

HISTORY OF COMPLAINT.....

.....

.....

ORAL CONDITION: ☐ EXCELLENT ☐ AVERAGE ☐ POOR

BPE ☐☐☐ ☐☐☐

PERIODONTAL STATE: ☐ EXCELLENT ☐ AVERAGE ☐ POOR

ADDITIONAL INFORMATION.....

DOCUMENTS	SUPPLIED
INTRA ORAL RADS	
EXTRA ORAL RADS	
STUDY MODELS	
PATIENT RECORDS	

REFERRING PRACTITIONER:

NAME..... SURNAME.....

PRACTICE.....

ADDRESS.....

..... POSTCODE.....

EMAIL..... TELEPHONE.....

SIGNED ..... PRINT NAME ..... DATE .....

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