



Alternatively you can fill in the form below and post it to us to commence your referral (Please retain a copy for your records)

1 Complaint / Treatment Required

- Implants
- Oral Surgery
- Invisalign
- Root Canal
- Sedation
- OPG

2 Please fill in the fill details of the treatment requested / Justification for radiograph / Area of interest

3 Patients Details

Name _____

D.O.B. _____ Sex _____

Address _____

Tel No. _____

Mobile _____

Email _____

4 Please state what has been enclosed

- X-Rays
- Medical History Sheet
- Other _____
- Casts

5 Medical History (Pregnancy for OPG)

6 Referring Dentist

Dentist Name _____

Practice Name _____

Address _____

Tel No. _____

Fax No. _____

Mobile _____

Email _____

Please indicate for OPG if you would like:

- Print out
- Return by secure email

7 Do you require more referral forms?

- Yes
- No

Signature of referring dentist:

GDC No. _____ Date _____

