

Patient Referral Form

Your Details:

Title: _____ Surname: _____ First Name/s: _____

Practice Address: _____

Work: _____ Mobile: _____

Email: _____

Patient Details:

Title: _____ Surname: _____ First Name / s: _____

DOB: _____ Contact Address: _____

Mobile: _____ Home: _____

Work: _____ Email: _____

Reason for Referral:

- | | | | |
|-----------------------|--------------------------|------------------------------|--------------------------|
| Periodontics | <input type="checkbox"/> | Implants | <input type="checkbox"/> |
| Endodontics | <input type="checkbox"/> | Orthodontics | <input type="checkbox"/> |
| Prosthodontics | <input type="checkbox"/> | Sleep Apnoea Therapy | <input type="checkbox"/> |
| Restorative Dentistry | <input type="checkbox"/> | Oral & Maxillofacial Surgery | <input type="checkbox"/> |
| Paedodontics | <input type="checkbox"/> | TMJ Disorders | <input type="checkbox"/> |

Does the patient have health insurance? Yes No

Note: Our consultants are accredited with several health insurance companies and if your patient is insured there is a likelihood that they might be able to claim some of the fees for their consultation and treatment.

Referral Notes:

Any Further Information enclosed:

Xrays CT Scan Study Models Photographs

Please indicate which service you would like us to provide for your patient:

See patient for consultation and report / advice / treatment planning only

See patient for consultation, report and treatment

Would you wish to be present at any stage of treatment?

Yes

No

If Yes, please state which stage:

How would you like to be notified of your patients progress?

Email

Post

Notes:

Prior to implant treatment or during complex treatment, we may co-ordinate hygienist appointments in-house. However, once the treatment is completed we will refer your patient back to your hygienist with notes on recommended home care. Due to the risk of peri-implantitis, it is normally a condition of our 5 year guarantee that the patient sees an implant-trained hygienist at prescribed intervals during the year. If you prefer your patient to continue visiting our implant-trained hygienist for this specific after-care, we are happy to oblige.

It is our pledge that ALL patients will be returned to your care at the end of treatment and we will NOT provide any non-essential treatment outside the remit of your referral without consulting you first. However, for certain treatments we would like to recall the patient at yearly intervals for a review and audit of our work. Please tick the box below if you would NOT like the patient to return to us for review appointments since this will have a bearing on our ability to guarantee our work.

No recalls or review appointments requested after end of treatment

Any Comments:

Thank you for your referral