# PATIENT REFERRAL FORM

## PATIENT DETAILS:

Mr / Mrs / Miss / Ms / Dr / Other _____

Date of Birth ____ /____ /____

First Name: _____

Surname: _____

Address: _____

_____

_____

Postcode: _____

Tel Home: _____

Tel Mobile: _____

Tel Work: _____

E-mail: _____

Preferred method of contact: _____

Have we seen the patient before? Yes / No

REFERRED BY: _____

Address: _____

_____

_____

Telephone: _____

Signature: _____

Date: _____

## TREATMENT REQUIRED:

☐ PERIODONTICS ☐ COSMETIC/RESTORATIVE ☐ ORTHODONTICS

☐ ENDODONTICS ☐ IMPLANTS/PROSTHODONTICS ☐ HYGIENE

B P E

RADIOGRAPHS: ☐ Enclosed: ☐ Emailed: ADDITIONAL INFORMATION: ☐ Enclosed: ☐ Emailed:

DETAILS: _____

_____

HOW NERVOUS IS THE PATIENT: 1 2 3 4 5 6 7 8 9 10 10 being most nervous

PATIENT MOTIVATION LEVEL: High / Medium / Low

| RELEVANT DENTAL HISTORY<br>(please continue on separate sheet if needed) | RELEVANT MEDICAL HISTORY |
|---|---|
| | |

SMILE DESIGN DENTAL PRACTICE, 33 HIGH STREET, WENDOVER, BUCKINGHAMSHIRE HP22 6DU
TEL: 01296 624163 EMAIL: REFERRALS@SMILEDESIGNDENTAL.CO.UK WWW.SMILEDESIGNDENTAL.CO.UK

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_____

_____

Telephone: _____

Signature: _____

Date: _____

## 3D SCAN & OPT

### TREATMENT REQUIRED:

☐ 3D SCAN

☐ OPT

SECTIONAL OPT

| Right sextant & TMJ | Central sextant | Left sextant & TMJ |
|---|---|---|

(please highlight desired sextants)

ADDITIONAL INFORMATION: ☐ Enclosed: ☐ Emailed:

DETAILS: _____

_____

HOW NERVOUS IS THE PATIENT: 1 2 3 4 5 6 7 8 9 10 10 being most nervous

IMAGING STENT TO BE SUPPLIED BY REFERRING DENTIST? Maxilla Yes / No Mandible Yes / No
(if required)

| REGION OF SPECIFIC CLINICAL INTEREST: |
|---|
| |

| PROPOSED COURSE OF TREATMENT: |
|---|
| |

| RELEVANT DENTAL HISTORY: |
|---|
| |

| RELEVANT MEDICAL HISTORY: |
|---|
| |

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