

# Patient Referral Form

**Please accept my referral to Linden Dental Centre for:**

- |  |   |
|--|---|
| <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Oral surgery                 |
| <input type="checkbox"/> Orthodontic treatment | <input type="checkbox"/> Other (please specify) ..... |
| <input type="checkbox"/> Implant treatment     | .....   |

**Patient**

Name .....	Date of birth .....
Address .....	Telephone (daytime) .....
.....	Telephone (evening) .....
Postcode .....	E-mail address .....

**Referring dentist**

Practice name .....	Dentist .....
Address .....	Telephone (daytime) .....
.....	Fax .....
Postcode .....	E-mail address .....

**The patient...**

- Is new to this practice
- Attends this practice regularly
- Needs a consultation

**The problem is...**

- Generalised
- Localised to (please indicate) .....
- .....

**The patient...**

- Pain
- Swelling
- Bleeding
- Bad taste in the mouth
- Recurrent abscesses

**The problem is...**

- Tooth mobility
- Difficulty chewing
- Poor appearance of Teeth
- Other problems (please specify) .....
- .....

**Further information**

Any additional problems .....

Any relevant medical history .....

Any other information you think might be helpful .....

.....

**Please find enclosed (to be returned after use)**

- |   |  |
|---|--|
| <input type="checkbox"/> Radiographs (number) ..... | <input type="checkbox"/> Test results (test names) ..... |
|---|--|