referral

Buckle Advanced Dental Care

referring dentist

Name _____ Date _____

Address _____ Tel _____

_____ Fax _____

Postcode _____ Email _____

patient details

Name _____ Home _____

Address _____ Work _____

_____ Mob _____

Postcode _____ DOB _____

relevant medical history

Please include any radiographs which may help in evaluating the patient. We will return them to you after use.

type of referral (please tick)

- ☐ Patient new to your practice
- ☐ Regular attender

main reason(s) for referral

(please tick all that apply)

- ☐ Restorative
- ☐ Implant
- ☐ Endodontic
- ☐ TMJ
- ☐ Other (please specify) _____

tooth notation

_____

tell us more

_____

further information

Are there any radiographs enclosed? ☐ Yes ☐ No

Has the patient been informed of the cost of consultation? ☐ Yes ☐ No

Has the patient been made aware of the level of investment that may be required? ☐ Yes ☐ No

Has the patient been informed of the location of Buckle Advanced Dental Care? ☐ Yes ☐ No

sedation required (oral / IV)

Yes ☐ No ☐

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