

Patient Referral Form

Please accept my referral to Elgin Dental Care for:

- Periodontal treatment
- Inman Aligner
- Implant treatment
- Oral surgery
- Endodontic treatment
- Hygiene therapy

Date of most recent dental examination:

Prescription to dental hygienist/therapist:

Patient

Name

Date of Birth

Address

Telephone (daytime)

Telephone (evening)

Telephone (mobile)

Postcode

Email

Referring Dentist

Practice name

Dentist

Address

Telephone (daytime)

Fax

Email

Postcode

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)

Radiographs (number)

Test Results (test names)

Signature of Dentist

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Date

Name of dentist & GDC No.

Practice stamp

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