DENTAL REFERRAL REQUEST FORM

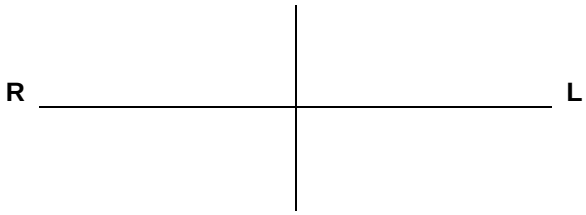
PATIENT DETAILS:

Title: **Name:** **D.O.B**
Address:

Postcode: **TEL:**
Email:

I would be grateful if you could see the above patient for:

TEETH TO BE TREATED – PLEASE ANNOTATE AS REQUIRED:



O **ORAL SURGERY** □ private □ independent (registered NHS patients only)
O **IV SEDATION FOR ANXIOUS PATIENTS**
O **ENDODONTICS**
O **IMPLANTS**

PERIODONTICS (private only)
O Periodontal assessment and treatment
The problem is □ generalised □ localised to……..
O Perio Surgery, please specify:
□ Gingival Plastic Surgery □ Crown Lengthening □ Ridge Augmentation
□ Surgical Endondontics

Associated problems:
□ Pain □ Recurrent abscesses □ Swelling □ Tooth Mobility
□ Bleeding □ Bad breath/taste. □ Other……

BPE score:

Please indicate if you/your hygienist will be willing to carry out maintenance therapy once the active treatment has been completed: **YES / NO**
In the meantime patients **will continue to see you** for routine dental check ups and treatment.

Relevant Medical History:

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Referring Dentist Name: ……..
Address……..…
……..
……..…..
Tel: …….. Date.....
Email:……..

Please send to: LDSC, Gloucester House, 150 Woodside Lane, London N12 8TP Please fax to: 020 8445 1265
Tel: 020 8445 1199