WELLINGTON DENTAL PRACTICE

IMPLANT & ORAL / ENDODONTIC SURGERY REFERRAL

Wellington Dental Practice
47 High Street
Somerset
TA21 8QY

PATIENT DETAILS

Title	
Full Name	
Date of Birth	
Address	
Postcode	

Email Address	
Home Telephone	
Work Telephone	
Mobile Telephone	

IS THIS AN URGENT REFERRAL ☐ YES ☐ NO

REASON FOR REFERRAL (PLEASE TICK ALL THAT APPLY)

- ☐ OPINION ONLY
- ☐ ORAL SURGERY / COMPLEX EXTRACTIONS
- ☐ ENDODONTIC SURGERY / APISECTOMY
- ☐ OTHER REASON / DESCRIPTION (PLEASE GIVE DETAILS BELOW)
- ☐ DENTAL IMPLANT SINGLE / MULTIPLE
- ☐ IMPLANT RETAINED DENTURE / BRIDGE
- ☐ BONE AUGMENTATION / GRAFTS / SINUS LIFT / CROWN LENGTHENING
- ☐ CT SCAN

Has the patient been informed of the cost/s of the consultation / treatment? ☐ YES ☐ NO

MEDICAL HISTORY (PLEASE PROVIDE / ATTACH DETAILS OF ANY MEDICAL CONDITIONS AND MEDICATION)

REFERRING DENTIST DETAILS

Dental Practice	
Dentist Name	
Address	
Postcode	

Telephone Number	
Email Address	
Signed	
Date