

WELLINGTON DENTAL PRACTICE

Periodontal Referral

Wellington Dental Practice, 47 High Street, Wellington,
Somerset, TA21 8QY

PATIENT DETAILS

Title	
Full Name	
Date of Birth	
Address	
Postcode	

Email Address	
Home Telephone	
Work Telephone	
Mobile Telephone	

REASON FOR REFERRAL (PLEASE TICK ALL THAT APPLY)

- OPINION ONLY
- PERIODONTAL TREATMENT
- OTHER REASONS / SYMPTOMS (PLEASE GIVE DETAILS BELOW)

INVESTIGATIONS

- Has the patient been informed of the cost of the consultation / treatment? YES NO
- Has treatment been attempted? YES NO
- Pre-operative radiograph enclosed? YES NO
- Is the patient dentally fit? 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	