WELLINGTON DENTAL PRACTICE

REFERRAL FORM

PATIENT DETAILS

TITLE	
FULL NAME	
DATE OF BIRTH	
ADDRESS	
POSTCODE	

EMAIL	
HOME TELEPHONE	
MOBILE	
WORK TELEPHONE	

REASON FOR REFERRAL (PLEASE TICK ALL THAT APPLY)

DENTAL IMPLANTS / ORAL SURGERY / SEDATION ☐		ENDODONTICS ☐
PERIODONTICS ☐	PROSTHODONTICS ☐	RESTORATIVE DENTISTRY ☐

REFERRAL DETAILS, CONCERNS & MEDICAL HISTORY

	YES	NO
Has the patient been informed of the cost of the consultation?		
Has treatment been attempted?		
Pre-operative radiograph(s) enclosed? (mandatory for endodontic referrals)		
Is the patient dentally fit?		

REFERRING DENTIST DETAILS

DENTAL PRACTICE	
DENTIST NAME	
ADDRESS	
EMAIL	
TELEPHONE	