HARLEY STREET DENTAL STUDIO

ADVANCED DENTAL SOLUTIONS

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Referral form

How to complete this form:

01. Please insert your practice and dentist details
02. Tick the referral speciality you require
03. Please insert the patient details
04. Fill in the reason for referral
05. Note any relevant medical history
06. Indicate any enclosures sent by ticking the relevant boxes
07. Fax, post or email the form to us

YOUR PRACTICE DETAILS

Title Name

Practice name

Practice address

Postcode

Telephone

Fax

Email

Q. Have you referred to us before? ☐ Yes ☐ No

SPECIALITY REQUIRED

	URGENT	
Implantology	☐	☐
Cosmetic dentistry	☐	☐
Prosthodontics	☐	☐
Periodontics	☐	☐
Endodontics	☐	☐
Orthodontics	☐	☐
Oral surgery	☐	☐
Digital radiography	☐	☐
IV sedation	☐	☐
Facial treatments	☐	☐

PATIENT DETAILS

Title First name

Surname

Date of birth

Address

Postcode

Daytime contact telephone

Mobile

Fax

Email

REASON FOR REFERRAL

I would like to be present during the consultation/treatment ☐ Yes ☐ No

I would like the specialist to contact me to discuss the case ☐ Yes ☐ No

RELEVANT MEDICAL HISTORY

ENCLOSURES: ☐ X-rays ☐ Models ☐ Photographs

Q. Has the patient been given an estimate of our fees? ☐ Yes ☐ No