Queensway Dental Practice

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Periodontics Oral surgery Sedation Implants
Referral Form

Date of Referral
Name of Dentist Address
Has the patient attended our Clinic before? Yes No

Patient's details:
First Name
Surname
Address
Postcode Tel:
Home
Date of Birth Work/ Mobile

Periodontics:
The patient requires:
Treatment for Periodontal disease Mucogingival Surgery
Crown lengthening
Other (add to comments below)

Implant Assessment:
Other Comments Does the patient smoke?
Is urgent assessment required? Yes Which teeth require replacement?

Sedation:
Please state what treatment to be provided under intravenous sedation?
Conservative dentistry
Endodontics
Periodontics
Oral surgery
Is the patient in pain Yes/No
Surgical Extraction(s) Crown Lengthening Apicectomy
Third molar extraction
The Patient would like to be treated under: -
Local anaesthetic
Intravenous Sedation
What is the indication for the surgery requested?

Please feel free to add any additional information on the reverse of this form or enclose a letter of referral. Please include any current radiographs, we will return the radiographs to you upon completion of treatment. Thank you for referring this patient. Unless you have booked an appointment with us for the patient, we will contact them directly to arrange a consultation appointment.

Additional information

Enclosures
Radiographs Yes/No Clinical Notes Yes/No Photographs Yes/No Study Models Yes/No