DENTAL REFERRAL REQUEST FORM

PATIENT DETAILS:

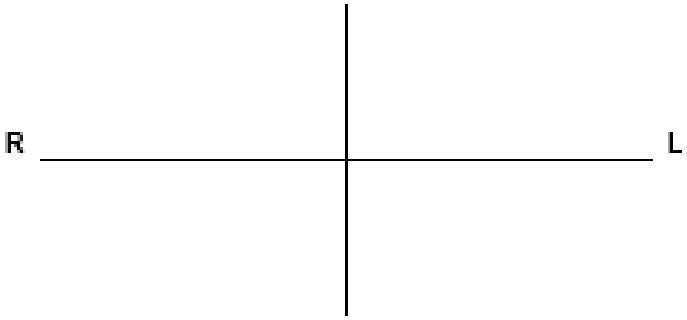
Title: **Name:** **D.O.B**

Address:

Postcode: **TEL:** **Email:**

I would be grateful if you could see the above patient for:

TEETH TO BE TREATED
PLEASE ANNOTATE AS REQUIRED:



- O ORAL SURGERY (private only)
- O IV SEDATION FOR ANXIOUS PATIENTS
- O GENERAL DENTISTRY UNDER SEDATION
- O IMPLANTS
- O OPG XRAY
- O PROSTHODONTICS

PERIODONTICS (private only)

O Periodontal assessment and treatment

The problem is ☐ generalised ☐ localised to……..

O Perio Surgery, please specify:

☐ Gingival Plastic Surgery ☐ Crown Lengthening ☐ Ridge Augmentation ☐ Surgical Periodontics

Associated problems:

☐ Pain ☐ Recurrent abscesses ☐ Swelling ☐ Tooth Mobility

☐ Bleeding ☐ Bad breath/taste. ☐ Other……

BPE score:

Please indicate if you/your hygienist will be willing to carry out maintenance therapy once the active treatment has been completed: **YES / NO**

In the meantime, patients **will continue to see you** for routine dental check-ups and treatment.

Relevant Medical History:

Referring Dentist

Name: ……..

Address: ……..……

Tel: ……

Email: ……

Date: ……..

Please send to: LDSC, Gloucester House, 150 Woodside Lane, London N12 8TP Please email to info@ldsc.co.uk
Tel: 020 8445 1199