THE STAINES CENTRE OF
DENTAL EXCELLENCE

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periodontics ■ endodontics ■ oral surgery ■ sedation ■ implants ■

# referral form

## Patient details

First Name _____ Surname _____

Address _____

_____

_____

Postcode _____ Date of Birth _____

Tel: Home _____ Work/ Mobile _____

## Referring dentist's details

Date of Referral _____

Name of Dentist _____

Address _____

_____

Postcode _____ Tel: _____

Has the patient attended our Clinic before? Yes ☐ No ☐

## Relevant medical history

## Endodontic referral

- ☐ Consult for Opinion Only
- ☐ Root Treatment
- ☐ Removal of Broken Instruments
- ☐ Apicectomy

Please advise of any previous treatment on this tooth and treatment planned for the future (add to comments below)

Other Comments

## Sedation referral

Please state what treatment to be provided under intravenous sedation?

- ☐ Conservative dentistry
- ☐ Endodontics
- ☐ Periodontics
- ☐ Oral surgery

Is the patient in pain Yes ☐ No ☐

Other Comments

## Periodontal referral

The patient requires:

- ☐ Treatment for Periodontal disease
- ☐ Mucogingival Surgery
- ☐ Crown lengthening
- ☐ Other (add to comments below)

Other Comments

## Implant referral

Does the patient smoke? Yes ☐ No ☐

Is urgent assesment required? Yes ☐ No ☐

Which teeth require replacement?

Other Comments

## CT Scanning referral

Which jaw do you require?

- ☐ Mandible
- ☐ Maxilla

☐ 5x4cm scan of local area

(Please indicate the region in the box below)

What is the indication for your scan?

Kodak planning software will be provided. Please advise us if you require Simplant™ software.

## Surgery referral

- ☐ 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 | ☐ |
| Clinical Notes | Yes | ☐ |
| Photographs | Yes | ☐ |
| Study Models | Yes | ☐ |