

ORTHODONTIC REFERRAL FORM

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Specialist In Orthodontics

PATIENT DETAILS	
<i>Name:</i>	<i>DOB:</i>
<i>Address:</i>	<i>Work Tel (W):</i> <i>Home Tel (H):</i> <i>Mobile Tel (M):</i> <i>Email (E):</i>
<i>Please indicate patients preferred method of contact: W</i> <input type="checkbox"/> <i>T</i> <input type="checkbox"/> <i>E</i> <input type="checkbox"/> <input type="checkbox"/>	

PATIENT PRESENTING COMPLAINT

REFERRAL TYPE	RELEVANT RADIOGRAPHS ENCLOSED
<input type="checkbox"/> <i>NHS (Patients aged 17 and under)</i> <i>(Patients with a Teesside address; 'TS' postcode only)</i>	<input type="checkbox"/> <i>DPT</i>
<input type="checkbox"/> <i>PRIVATE (Any patient regardless of age or postcode)</i>	<input type="checkbox"/> <i>Periapicals</i>
	<input type="checkbox"/> <i>Bitewings</i>

OTHER INFORMATION / MEDICAL CONDITIONS

REFERRING DENTIST DETAILS	
<i>Name:</i>	
<i>Address:</i>	<i>Telephone</i>
	<i>Email:</i>

Signed:	Date:
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Address: 170 Queensway, Billingham, Teesside, TS23 2NT

T: 01642 554667 F: 01642 531799 E: dental@queensway.co.uk W: www.queensway.co.uk

For additional copies of this referral form please refer to our website

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