

PRIVATE SPECIALIST PERIODONTOLOGY REFERRAL FORM

Dr Geoffrey Sharpe BDS MFDS, RCPS MSc MRD (perio) RCSEd

Specialist in Periodontics

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

RELEVANT MEDICAL HISTORY

REFERRAL REQUEST	ADDITIONAL INFORMATION (please give details below)
<input type="checkbox"/> Periodontal Treatment <input type="checkbox"/> Dental Implants <input type="checkbox"/> Any Other Treatment (Please give info) <input type="checkbox"/> Crown lengthening <input type="checkbox"/> Soft tissue surgery	

RELEVANT RADIOGRAPHS ENCLOSED
<input type="checkbox"/> DPT <input type="checkbox"/> Bitewings <input type="checkbox"/> Periapicals

REFERRING DENTIST DETAILS	
Name:	
Address:	Telephone
	Email:

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