
PATIENT DETAILS

Name: Date of birth:
Address: Telephone (main):
..... Telephone (mobile):
Postcode: Email:

IS THIS REFERRAL URGENT? Yes No

REASON FOR REFERRAL (please tick all relevant boxes)

- | | |
|---|--|
| <input type="checkbox"/> Opinion only | <input type="checkbox"/> Abutment for bridge/new crown |
| <input type="checkbox"/> Endodontic treatment | <input type="checkbox"/> Existing post/post removal |
| <input type="checkbox"/> Difficult access | <input type="checkbox"/> Non-visible/sclerosed canals |
| <input type="checkbox"/> Difficult tooth morphology (curved canals) | <input type="checkbox"/> Broken instrument |
| <input type="checkbox"/> Other reason (please specify below) | |

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INVESTIGATIONS

Has the patient been informed of the cost of the consultation/treatment? Yes No
Has the patient been informed of the location of the practice? Yes No

MEDICAL HISTORY

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- Attempted treatment No treatment attempted Pre-operative radiograph enclosed

REFERRING DENTIST DETAILS (please ensure this section is fully completed)

Name: Telephone:
Address: Email:
..... Signed:
Postcode: Date: