

PATIENT DETAILS

Name: ..... Date of birth: .....

Address: ..... Telephone (main): .....

..... Telephone (mobile): .....

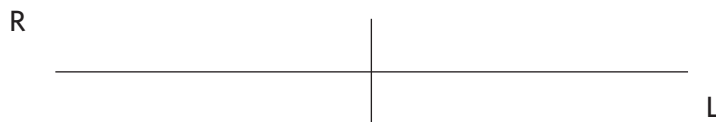
..... Email: .....

Postcode: .....

REASON FOR REFERRAL (in accordance with policy referral protocols)

- Extraction of special difficulty
- Removal of wisdom teeth as indicated by NICE
- Removal of buried roots/fractured or root fragments
- Extraction of simple impacted, ectopic or supernumerary teeth
- Exposure of teeth (with Orthodontic Treatment Plan)
- Benign minor soft tissue surgery (polyps, mucocoele, hyperplasia). Not any unknown lesions (please include hospital reference)
- Apicectomy of single-rooted tooth, RCT'd teeth (radiograph must be included)
- Removal or enucleation of simple dental cysts

CLINICAL DETAILS (teeth indicated for treatment if appropriate)



HISTORY

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RELEVANT RADIOGRAPHS ENCLOSED

- DPT
- Bitewings
- Periapical

INDICATION FOR SEDATION

- No indication
- Anxiety
- Invasive procedure
- Co-operation

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RELEVANT MEDICAL (ESSENTIAL) ASA 1&2

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GMP DETAILS

Name: ..... Telephone: .....  
Address: ..... Email: .....  
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Postcode: .....

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

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