# PATIENT REFERRAL FORM

SQUARE MILE DENTAL CENTRE

## REFERRING DENTIST DETAILS

First Name

Surname

Telephone

Email

Address

Postcode

## PATIENT DETAILS

First Name

Surname

Telephone

Email

D.O.B.

Address

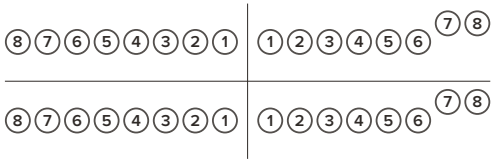
Postcode

## REFERRAL FOR (PLEASE TICK)

- ☐ Implants
- ☐ Restorative Dentistry
- ☐ Periodontics
- ☐ Children's Dentistry
- ☐ Endodontics
- ☐ Denture Service
- ☐ Orthodontics
- ☐ Oral Surgery

## REASONS FOR REFERRAL

## TEETH (PLEASE TICK)




| | Yes | No |
|---|---|---|
| **X-ray to be returned?** | ☐ | ☐ |
| **Patient for consultation only** | ☐ | ☐ |

**How would you like to be notified of the patient's progress?**

☐ Email ☐ Post ☐ Phone

## OUR REFERRAL CHARTER

At the end of the specified treatment, we will return your patients back to you for their continued dental care. We have a strict policy of not taking on any patient who has been referred to us by another practice. We will keep you informed at the beginning and the end of the treatment. If the patient has only been referred for assessment planning, a letter will be sent back to you as soon as possible. Please feel free to contact the practice at any time if you have any questions or queries or if you would like to discuss any aspect of the treatment.

Signature

Date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