PATIENT REFERRAL FORM

RESTORE
SPECIALIST REFERRAL CENTRE
DEDICATION ◆ TRUST ◆ SUPPORT

Patient Details

Title: | First Name: | Last Name:

Address: | DOB:

Male ☐ Female ☐

Mobile: | Home:

Work: | Email:

Referring Dentist

Title: | First Name: | Last Name:

Practice Name: | Date of Referral:

Address: | Mobile: | Work: | Email:

Medical History:

Reason for Referral:

Urgent: Yes ☐ No ☐

Referring Speciality:

Periodontics	☐	Orthodontics	☐
Endodontics	☐	Paediatric Dentistry	☐
Prosthodontics	☐	Oral Surgery	☐
Restorative Dentistry	☐	IV Sedation	☐
Implant Dentistry	☐	Facial Aesthetics	☐

Enclosures:

Xrays	☐
CT Scan	☐
Study Models	☐
Photographs	☐

Additional Information:

Signature: | Date:

If you require more referral forms please tick ☐

RESTORE , 30A Hewell Road, Barnt Green, Birmingham, Worcestershire, B45 8NE
T: 0121 445 3697 E: referrals@restore-dental.co.uk W: restore-dental.co.uk