0207 373 6899
71 Queen's Gate South Kensington London SW7 5JT

Queen's Gate
Dental Practice

Refferal Form

Patients details

First Name _____ Surname _____

Address _____

_____

_____

_____ Postcode _____

Date of Birth _____

Tel (Home)_____ Work / Mobile _____

Referring dentist's details

Date of referral _____

Name of dentist _____

Address _____

_____

_____ Postcode _____

Tel _____

Has the patient attended our Clinic before? Yes ☐ No ☐

Relevant medical history

Endodontic referral

☐ Consult for opinion only ☐ Root treatment

☐ Removal of broken instruments ☐ Apicectomy

Please advise of any previous treatment on this tooth and treatment planned for the future (add comments below)

Other comments:

Sedation referral

Please state what treatment to be provided under intravenous sedation

☐ Conservative dentistry ☐ Endodontics

☐ Periodontics ☐ Oral surgery

Is the patient in pain? Yes ☐ No ☐

Other comments:

Periodontal referral

The patient requires:

☐ Treatment for Periodontal disease ☐ Mucoginval Surgery

☐ Crown lengthening ☐ Other(add to comments below)

Other comments:

Implant referral

Does the patients smoke? Yes ☐ No ☐

Is urgent assessment required? Yes ☐ No ☐

Which teeth require replacement?

Other comments:

CT scanning referral

Which jaw do you require?

☐ Mandible

☐ Maxilla

☐ 5x4cm scan of local area

Please indicate the region in the box below

What is the indication of your scan? _____

_____

Surgery referral

☐ Surgical extraction(s) ☐ Apicectomy

☐ Crown lengthening ☐ Third molar extraction

The patient would like to be treated under:

☐ Local anaesthetic ☐ Intraveneous sedation

What is the indication for the surgery requested? _____

_____

Thank you for referring this patient. Unless you have booked an appointment with us for the patient, we will contact them directly to arrange a consultation appointment.

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www. queensgatedental.co.uk

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Additional Information

Enclousers

Please feel free to add any additional information on the reverse of this form or enclose a letter of referral. Please include any current radiographs,

- ☐ Radiograph
- ☐ Photographs
- ☐ Clinical Notes
- ☐ Study Models