Referral Form

VICARS CROSS DENTAL

Part of: *Perfect Smile Group*

PERFECT SMILE

Please complete this form in **BLOCK CAPITALS** in ink and tick where appropriate.

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perfectsmile-dental.com

Date: D D / M M / Y Y Y Y

Type of Referral: ☐ Sedation ☐ Implants ☐ Endodontics ☐ Invisalign ☐ OPG

Has the patient been to the practice before? Yes ☐ No ☐

PERSONAL DETAILS

Title e.g. Mr/Mrs/Ms: **Date of Birth:** D D / M M / Y Y Y Y

First Name: **Surname:**

Email:

Telephone Number: **Mobile Telephone Number:**

Address:

Town: **Postcode:**

Main Occupation:

TREATMENT REQUIRED

Conservation:

Reason for referral
(Please give as much information as possible)

Extractions (please specify if surgical):

Other Treatment:
(i.e Invisalign, Dental Implants, Periodontics, Endodontics, or Cosmetic Treatments)

MEDICAL CONDITIONS

☐ **Cardiac Problems** (Angina, Murmur, other Heart Problem)	☐ **Epilepsy**	☐ **Allergies** (Please specify)
☐ **Rheumatic Fever/Chorea**	☐ **Bleeding/Clotting Problems**	
☐ **Respiratory Problems**	☐ **Stickle Cell Status**	☐ **Any Other Relevant Information/Medication**
☐ **Diabetes**	☐ **Sedation Required**	

Please Note: Any relevant X-rays must be sent with this referral form along with the patients latest Medical History Form

Practice Name:

Referring Dentist Name:

Address: **Telephone Number:**

Signature: _____

Practice Stamp: