Surgical Specialist Referral

Balbirnie Oral Care

Patient Details

Surname:_____ First Name:_____

Address: _____

_____

_____ Postcode:_____

DOB: _____ Contact Tel. No: _____

Is the patient registered? Yes / No

Reason for referral and/or provisional treatment plan

We would welcome any relevant radiographs. These will be returned once treatment on referral has ended.

Additional details

Does the patient require sedation? Yes / No
Does the patient have a disability? Yes / No
Is the patient medically compromised? Yes / No

Please give additional detail if you have answered 'Yes' to any of the above

Dentist stamp:

Signature: _____

Date: _____

Tel No: _____

Have you enclosed a medical history and relevant radiographs?
Post to: Balbirnie Oral care Ltd, 1 Balbirnie Road, Woodside, Glenrothes. KY76ED