ORAL SURGERY REFERRAL FORM

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THE RILEY DENTAL STUDIO

PATIENT DETAILS:

Patient Full Name: (Mr/Mrs/Ms/Miss/Dr).....

Patient Full Address: .....

.....

.....

Patient DOB: ..... / ..... / ..... **Tel:** (daytime) ..... (evening) .....

Patient E-mail: (optional) .....

RELEVANT MH: .....

.....

Tooth/Teeth to be treated:

Patient informed of approximate cost: ❑ Yes ❑ No

X-rays enclosed/quantities: ❑ PA/s x ____ ❑ OPG x _____

DETAILS OF TREATMENT REQUIRED:

REFERRING DENTIST:

Name: ..... **Signature:** .....

Practice Address: .....

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Tel: (daytime) ..... (evening) .....

Date of referral: ..... / ..... / ..... **E-mail:** .....

I have obtained consent to this referral from the patient or parent/guardian following my consultation to discuss their treatment options **Yes** ☐ **No** ☐

Thank you for referring this patient. Please include any current radiographs & a completed MH form. We will return the radiographs to you if required on completion of treatment. Unless you have booked an appointment with us on behalf of the patient we will contact them directly to do so.