



**QUICK REFERRAL**

Call us directly on 0118 966 5656

We'll do the rest

**GIPSY LANE**

ADVANCED DENTAL CARE

**URGENT REFERRAL**

+44 7531 367404

**PATIENT REFERRAL FORM**

Date of Referral: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Mr  Mrs  Ms  Other  \_\_\_\_\_ Home Telephone: \_\_\_\_\_

Surname: \_\_\_\_\_ Work Telephone: \_\_\_\_\_

Forename(s): \_\_\_\_\_ Mobile: \_\_\_\_\_

Address: \_\_\_\_\_ E-mail: \_\_\_\_\_

\_\_\_\_\_ Postcode: \_\_\_\_\_ Best Time to Call: \_\_\_\_\_

Referral For: Advice  Treatment  Has Patient been referred before: Yes  No

Please indicate type of referral:

Implants  Periodontics  Prosthodontics  Restorative Dentistry  Endodontics  Orthodontics

Oral and Maxillofacial Surgery  Dental Hygienist Services  IV Sedation

X-Rays Enclosed: Yes  No  \_\_\_\_\_ Study Cases Enclosed: Yes  No  \_\_\_\_\_

Referring Practitioner Details:

Mr  Mrs  Ms  Dr  \_\_\_\_\_ Address: \_\_\_\_\_

First Name: \_\_\_\_\_

Surname: \_\_\_\_\_ City / Town: \_\_\_\_\_ Postcode: \_\_\_\_\_

E-mail: \_\_\_\_\_ Telephone: \_\_\_\_\_

Signature: \_\_\_\_\_ Mobile: \_\_\_\_\_

Referral & Medical History Information: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

All patients who have been referred to the practice will be returned back to you once treatment has been completed (unless otherwise required). It is our policy to keep you informed at the beginning and end of treatment. If the patient has only been referred for assessment or treatment planning, a letter will be sent back as soon as possible.

Please feel free to contact the practice at any time if you have any questions or queries, or if you would like to discuss any aspect of the treatment with the specialist.

Thank you for your referral.

5a Gipsy Lane, Earley, Reading, Berkshire, RG6 7HF  
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