8 Darwin Court | Oxon Business Park | Shrewsbury | SY3 5AL
t: 01743 34 34 33 f: 01743 34 34 32
e: info@the-dentalspa.co.uk

the DENTAL SPA *

PATIENT REFERRAL FORM (1/2)

If you prefer to discuss a case prior to referral please contact a Patient Advisor who will direct your call accordingly.

Referral type (please tick)		
☐ Dentures/Crowns/Bridges	☐ Dental implants	☐ Orthodontics
☐ Occlusion	☐ Oral surgery	☐ Hygiene referral

Referring Dentist details		
Title:	Name:	
Practice address:		
Tel No:	Fax No:	Email:
Preferred communication method:	☐ Letter ☐ Telephone ☐ Fax ☐ Email	

Patient details		
Title:	Name:	DOB:
Home address:		
Tel No:	Fax No:	Email:
Preferred communication method:	☐ Letter ☐ Telephone ☐ Fax ☐ Email	

Medical history (tick box if yes and provide details)
☐ The patient is currently undergoing treatment from their GP and/or specialist:
☐ The patient is currently taking medication/s and/or has an underlying medical condition:

Dental history (tick box if yes)	
☐ The patient attends regularly	☐ The patient is periodontally stable
☐ The patient is very nervous about treatment	☐ The patient is having additional dental treatment

Special history (tick box if yes)	
☐ The patient smokes	☐ The patient lives alone
☐ The patient has a relevant physical disability	☐ The patient has additional special needs

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PATIENT REFERRAL FORM (2/2)

Reason for referral
History of reason for referral:
How long has the problem been apparent?
Which treatment modalities have been tried?
Please give details of any relevant treatment to date:

Any other information (tick box if yes)	
☐ Enclosures	☐ Enclosures to be returned

NB Your patient will be referred back to you at the end of any treatment. Thank you for your kind referral.

Referring Dentist Signature: …….. Date: ……

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