Referral Form

Wightwick Dental Practice
A Brighter Healthier Smile

Title:
Forenames:
Surname
Address:

City/Town:
Postcode:

Date of Birth:
Home Tel No.
Mobile Tel No.
Work Tel No.
Email:
Best Time to call:
Date of Referral:

Has the patient been referred before? ☐ Yes ☐ No

Type of referral:

☐ Implantology/Prosthdontics
☐ Oral Surgey
☐ OPG/CBCT Scan
☐ Dental Hygiene Services
☐ Treatment under inhalation Sedation

Referral for: ☐ Advice ☐ Treatment
X rays enclosed: ☐ Yes ☐ No
Case study enclosed: ☐ Yes ☐ No

Referring Practitioner

Title:
Forename:
Surname:
Email:

Practice Name:
Address:
Postcode:
Tel No.
Signature:

Our Referral Guarantee

A clinician accepting a patient on referral will only undertake treatment they feel to be appropriate and that which lies within their competency. If the accepting clinician feels that alternative or additional treatment is required, this will be discussed with both the referring clinician and the patient and consent obtained for an amended treatment plan and any costs involved. Unless otherwise agreed with the referring clinician the accepting clinician will only carry out treatment in the capacity for which the patient has been referred to him/her.

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