REFERRAL FORM

Wightwick Dental Practice
A Brighter Healthier Smile

PATIENT DETAILS

Forenames:
Surname:
Address:

City / Town:
Postcode:

Date of Birth:
Home Tel:
Mobile Tel:
Work Tel:
Email:
Best time to call:
Date of referral:

Has the patient been referred before? Yes ☐ No ☐

TYPE OF REFERRAL:

☐ Orthodontics
☐ Oral Surgery
☐ Dental Implants
☐ OPG / CBCT Scan
☐ Dental Hygiene
☐ Treatment under Inhalation Sedation

Referral for: ☐ Advice ☐ Treatment

Xrays enclosed: ☐ Yes ☐ No

Relevant Medical History _____

_____

REFERRING PRACTITIONER

Title:
Forname:
Surname:
Email:

Practice Name:
Address:

Postcode:
Tel No:
Signature:

A clinician accepting a patient on a 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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