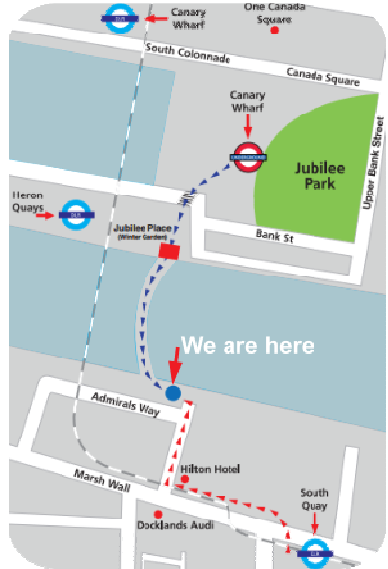


SPECIALIST DENTAL REFERRAL FORM

<p>1. Referring Practitioner</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="padding: 2px;">Practice Name</td></tr> <tr><td style="padding: 2px;">Address</td></tr> <tr><td style="padding: 2px;"> </td></tr> <tr><td style="padding: 2px;"> </td></tr> <tr><td style="padding: 2px;"> </td></tr> <tr><td style="padding: 2px;"> </td></tr> <tr><td style="padding: 2px;">Email</td></tr> <tr><td style="padding: 2px;">Telephone</td></tr> </table> <p>2. Referral Instruction - please tick as appropriate</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 20px; text-align: center;"><input type="checkbox"/></td><td>Investigate and Treat</td></tr> <tr><td style="text-align: center;"><input type="checkbox"/></td><td>Opinion Required</td></tr> <tr><td style="text-align: center;"><input type="checkbox"/></td><td>Treatment is Urgent</td></tr> </table> <p>3. Referral Type –please tick as appropriate</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 20px; text-align: center;"><input type="checkbox"/></td><td>Endodontics</td></tr> <tr><td style="text-align: center;"><input type="checkbox"/></td><td>Periodontics</td></tr> <tr><td style="text-align: center;"><input type="checkbox"/></td><td>Prosthodontics</td></tr> <tr><td style="text-align: center;"><input type="checkbox"/></td><td>Oral Surgery / Medicine</td></tr> <tr><td style="text-align: center;"><input type="checkbox"/></td><td>Orthodontics</td></tr> <tr><td style="text-align: center;"><input type="checkbox"/></td><td>IV Sedation</td></tr> </table>	Practice Name	Address					Email	Telephone	<input type="checkbox"/>	Investigate and Treat	<input type="checkbox"/>	Opinion Required	<input type="checkbox"/>	Treatment is Urgent	<input type="checkbox"/>	Endodontics	<input type="checkbox"/>	Periodontics	<input type="checkbox"/>	Prosthodontics	<input type="checkbox"/>	Oral Surgery / Medicine	<input type="checkbox"/>	Orthodontics	<input type="checkbox"/>	IV Sedation	<p>4. Enter Case Description</p> <div style="border: 1px solid black; height: 150px; margin-top: 5px;"></div> <p>5. Enter Relevant Medical History</p> <div style="border: 1px solid black; height: 150px; margin-top: 5px;"></div>
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<p>6. Patient Details (in clear block capitals)</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%; padding: 2px;">Title</td> <td style="padding: 2px;">D.O.B</td> </tr> <tr><td colspan="2" style="padding: 2px;"> </td></tr> <tr><td colspan="2" style="padding: 2px;">First Name</td></tr> <tr><td colspan="2" style="padding: 2px;">Last Name</td></tr> <tr><td colspan="2" style="padding: 2px;"> </td></tr> <tr><td colspan="2" style="padding: 2px;">Address</td></tr> <tr><td colspan="2" style="padding: 2px;"> </td></tr> <tr><td colspan="2" style="padding: 2px;"> </td></tr> <tr><td colspan="2" style="padding: 2px;">Postcode</td></tr> <tr><td colspan="2" style="padding: 2px;"> </td></tr> <tr><td colspan="2" style="padding: 2px;">Daytime Telephone</td></tr> <tr><td colspan="2" style="padding: 2px;"> </td></tr> <tr><td colspan="2" style="padding: 2px;">Email</td></tr> </table>	Title	D.O.B			First Name		Last Name				Address						Postcode				Daytime Telephone				Email		
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