WOKING
DENTAL CARE

5A Oriental Road, Woking,
Surrey, GU22 7AH
TELEPHONE : 01483 763360
admin@wokingdentalcare.co.uk
www.wokingdentalcare.co.uk

Periodontal & Dental Implant Referral Form

REFERRING PRACTITIONER:

NAME: _____

ADDRESS: _____

_____ POSTCODE: _____

TEL: _____ FAX: _____

MOBILE: _____ EMAIL: _____

PATIENT DETAILS:

DOES THE P ATIENT HAVE PRIV ATE HEALTH INSURANCE (PLEASE TICK) YES ☐ NO ☐

SURNAME: _____ FORENAMES: _____

TITLE: _____ DATE OF BIRTH: _____

ADDRESS: _____

_____ POSTCODE: _____

TEL (HOME): _____ TEL (WORK): _____

MOBILE: _____ EMAIL: _____

ORAL HEALTH STATUS (PLEASE TICK) :

ORAL HYGIENE: GOOD ☐ F AIR ☐ POOR ☐

SOFT TISSUE: NORMAL ☐ ABNORMAL ☐

REFERRAL REQUIREMENTS (PLEASE TICK) :

☐ PERIODONTAL ASSESSMENT	☐ MUCO - GINGIVAL SURGER Y	☐ GUIDED BONE REGENERATION (BONE GRAFTING)
☐ PERIODONTAL TREATMENT	☐ CROWN LENGTHENING	☐ GINGIVAL RECESSION
☐ IMPLANTOLOGY	☐ EXTRACTION / ORAL SUR GER Y	☐ OTHER

ENCLOSURES (PLEASE TICK) :

☐ PATIENT RECORDS	☐ STUDY MODELS	☐ PHOTOGRAPHS
☐ X-RAYS	☐ OTHER	

PATIENT MEDICAL HISTORY:

_____

_____

_____

COMMENTS:

_____

_____

PRACTITIONERS SIGNA TURE: _____ DATE: _____