Patient Referral Form

Referring Practitioner

Name:
Practice:
Practice Address:

Postcode:

Tel: Fax:
Mobile:
e-mail:

Patient Details

Name:
DOB:
Patient's Address:

Postcode:

Tel (home): Tel (work):
Mobile:
e-mail:

Referral Details

Referral for:	Tick	
Endodontics	❑	Reason for referral / diagnosis:
Implantology*	❑	Patients main complaint:
Periodontics		
Dentist	❑	
Hygienist	❑	
Restorative Dentistry	❑	
Invisalign	❑	
Cosmetic Dentistry	❑	

* For implants, will you be placing the final restoration? Yes ❑ No ❑

I have / have not enclosed radiographs: PA ❑ OPG ❑

Please complete for hygienist referrals only

Current BPE:

Please provide my patient with (tick all that apply):

- ❑ Basic periodontal examination. I understand that Code 4 will require a full periodontal assessment.
- ❑ Full periodontal assessment. If necessary, please refer to a periodontist.
- ❑ Scale and polish with OHI
- ❑ Non-surgical periodontal therapy (detox therapy). Please specify area/s
- ❑ Root surface instrumentation – please specify area/s
- ❑ Desensitisation – please specify area/s
- ❑ Fluoride application – please specify areas
- ❑ Please x-ray the affected area/s
- ❑ Local anaesthesia — Maximum cartridges per visit
  - ❑ Lignospan ❑ Scandonest plain ❑ Septanest
- ❑ Other requirements – give details below
- ❑ Supportive periodontal therapy (please circle) 1 year 2 years 3 years

Under current regulation, referrals to hygienists can be valid for 1-3 years. Please indicate by signing below that you are happy for the treatment you have indicated above to be carried out.

Please complete for all referrals

Signed (referring dentist): Date:

Practice Stamp: