ORION
DENTAL & IMPLANT CENTRE

PATIENT REFERRAL FORM

Date of referral: .....

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

Surname: .....

Forename(s): .....

Address: .....

City/town: .....

Postcode: .....

Date of birth: .....

Home tel no: .....

Work tel no: .....

Mobile no: .....

Email: .....

Best time to call: .....

Has the patient been referred before: Yes ☐ No ☐

Please indicate the type of referral:

Microscopic endodontics/retreatments ☐
Bruxism/TMD ☐
Full mouth rehabilitation/wear cases ☐
Dental implants ☐
Advanced restorative case (including minimally-invasive and biomimetic onlays) ☐
OPG ☐

Referral for: Advice ☐ Treatment ☐

X-rays enclosed: Yes ☐ No ☐ **Study models enclosed:** Yes ☐ No ☐

REFERRING PRACTITIONER DETAILS

Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

Surname: .....

Forename(s): .....

Email: .....

Signature: .....

Address: .....

City/Town: .....

Postcode: .....

Telephone no: .....

REFERRAL INFORMATION

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All patients who have been referred to the practice will be returned to you once treatment has been completed (unless otherwise requested). It is our policy to keep you informed at the beginning and end of treatment. If the patient has only been referred for an assessment or treatment planning, a letter will be sent back as soon as possible.

If you have any questions or queries, please don't hesitate to contact the practice to speak with the clinician.

THANK YOU FOR YOUR REFERRAL

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