SPECIALIST
DENTAL

Patient Referral form

Date of Referral: _____

Mr ☐ Mrs ☐ Ms ☐ Other ☐

Surname: _____

Forename(s): _____

Address: _____

_____

Post Code: _____

Date of Birth: _____

Home Tel No: _____

Work Tel No: _____

Mobile No: _____

Email: _____

Best Time To Call: _____

Has patient been referred before: Yes ☐ No ☐

Please indicate type of referral:

☐ Implants (Dr Nada Al-Nahi / Dr Sohaib Safiullah) ☐ Periodontics (Dr Nada Al-Nahi) ☐ Prosthodontics (Dr Sohaib Safiullah)
☐ Restorative Dentistry (Dr Sohaib Safiullah) ☐ Endodontics (Dr Sohaib Safiullah / Dr Federico Foschi)
☐ Orthodontics (Dr Sarah Burns / Dr Skjalg Johnsen) ☐ Oral & Maxillofacial Surgery +/- Sedation (Mr Mohammed Al-Gholmy)
☐ Dental Hygienist Services ☐ *OPG / *CBCT Scan (*delete as appropriate)

Referral for: Advice ☐ Treatment ☐

X-rays enclosed: Yes ☐ No ☐ Study casts enclosed: Yes ☐ No ☐

Referring Practitioner details:

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐

First Name _____

Surname _____

E-mail _____

Signature _____

Address _____

_____

City/Town _____

Post Code _____

Telephone No _____

Fax No _____

Referral Information:

_____

_____

_____

All patients who have been referred to the practice will be returned back 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 assessment or treatment planning, a letter will be sent back as soon as possible.

Please feel free to contact the practice at any time if you have any questions or queries, or if you would like to discuss any aspect of the treatment with the specialist.

THANK YOU FOR YOUR REFERRAL

Dr Sohaib Safiullah BDS (Lond) MSc FDS RCPS FDS (Rest Dent)
Registered Specialist in Prosthodontics, Periodontics, Endodontics & Restorative Dentistry

Dr Nada Al-Nahi BDS (Lond) MSc MClinDent (Perio) FDS MRD RCS (Eng)
Registered Specialist in Periodontics. Practice limited to Periodontics & Implant Dentistry

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