PATIENT REFERRAL FORM

edgbaston DENTAL CENTRE

Section A – Patient Details

Items marked with * are considered essential.
A referral will not be accepted without these details.

Patient Title – Mr / Mrs / Miss / Ms

Forename(s)*

Surname*

Full Address*

Postcode*

Date of Birth*

Contact Telephone*

Date of referral*

Section B – Treatment Required -

Referral Type?* **Intravenous Sedation** ☐ **Orthodontics** ☐ **Implantology** ☐ **Endodontics** ☐ **Oral Surgery** ☐

TREATMENT REQUIRED:

Please Note - 1) We do not see patients who are under the age of 18 for intravenous sedation.
2) Patients with an ASA score of 2 or greater will not be accepted for treatment.

Medical History*/Other

REFERRED BY:

Referring GDP*
Please Print

Practice Name*

Practice Telephone*

Practice Stamp*

GDP Signature*

Thank you for your referral. Please post this form so we can arrange a consultation.

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& Associates

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