

ORAL HEALTH REFERRAL PROFORMA

Date of Referral: / /

Dentist Details

Referring Dentist:

Name:

Address:

.....

Tel: Signature:

Patient Details

Name: D.O.B.....

Address:

.....

Postcode: Tel:

Medical History:

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Most Recent BPE:

Previous Periodontal Treatment:

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Patient Symptoms:

.....

Smoker: YES/NO

Referral Details

☐ Full periodontal assessment and periodontal programme

☐ Routine debridement of calculus and polish

Reason for referral:

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Thank you very much for your referral

Waterside Dentalcare, Waterside Court, Falmouth Road, Penryn, TR10 8AW
01326 378969 email: reception@watersidedentalcare.co.uk