



# Patient Referral

To:

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## Patient Details

Name.....

Address.....  
.....

Postcode..... Telephone.....

Date of Birth.....

## Nature of Clinical Problem

- |   |  |
|---|--|
| <input type="checkbox"/> Single tooth replacement | <input type="checkbox"/> Fixed bridge              |
| <input type="checkbox"/> Denture stabilisation    | <input type="checkbox"/> Full fixed reconstruction |
| <input type="checkbox"/> Other                    | <input type="checkbox"/> Surgical dentistry        |

## Relevant Medical History/Details of Clinical Problem

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.....  
.....

## Referring Practitioner

Name.....

Address.....  
.....

Postcode..... Telephone.....

Would you like to be involved with the treatment?       yes       no