

Referral Form



Garstang Dental Referral Practice Weind House Park Hill Road Garstang Lancashire PR3 1EL 01995 606091 reception.garstangdental@portmandental.co.uk www.garstangdrp.co.uk	Please tick which service(s) you require	
	Removable Prosthodontics - Dr Finlay Sutton	<input type="checkbox"/>
	Removable Prosthodontics & Restorative - Dr Zohaib Ali	<input type="checkbox"/>
	Orthodontic - Dr Hesham Ali	<input type="checkbox"/>
	Periodontic - Dr Syed Abad	<input type="checkbox"/>
	Endodontic - Dr Shakil Umerji	<input type="checkbox"/>
Implants - Dr Zohaib Ali/ Dr Syed Abad	<input type="checkbox"/>	

Referring Dentist

Name _____

Practice Address _____

Postcode _____ Phone Number _____

Email Address _____

Patient Details

Name _____ Date of Birth _____

Address _____

Postcode _____ Phone Number _____

Email Address _____

Relevant Medical History

Endodontic referrals	Tooth being referred for treatment _____ _____ _____ _____								
<table border="1"> <tr><td>Consultation only</td><td><input type="checkbox"/></td></tr> <tr><td>Root canal treatment</td><td><input type="checkbox"/></td></tr> <tr><td>Post and core placement</td><td><input type="checkbox"/></td></tr> <tr><td>Indirect restoration</td><td><input type="checkbox"/></td></tr> </table>	Consultation only	<input type="checkbox"/>	Root canal treatment	<input type="checkbox"/>	Post and core placement	<input type="checkbox"/>	Indirect restoration	<input type="checkbox"/>	If the tooth is deemed unrestorable or it is not feasible to undertake endodontic treatment, would you like Garstang Dental Referral Practice to arrange for extraction and replacement? Yes / No _____
Consultation only	<input type="checkbox"/>								
Root canal treatment	<input type="checkbox"/>								
Post and core placement	<input type="checkbox"/>								
Indirect restoration	<input type="checkbox"/>								

Please send a recent PA with the referral to dental.v80382@nhs.net All films posted will be returned after the patient has been seen

Reason for Referral

Orthodontic referrals – please provide details and radiographs of any teeth of poor prognosis and if you have an OPG please enclose or email us a copy

Signature _____ Date _____

We would be very grateful if relevant radiographs (**in particular for endodontics**) could be supplied at the time of referral. Please email radiographs to **dental.v80382@nhs.net** We will return all items to you.