7 Windsor Way, Knutsford, Cheshire, WA16 6JB
T: 01565 653480 E: info@kclinic.co.uk W: www.Kclinic.co.uk

Patient Referral

Please place a tick in the box of the referral type you require

Anxious Patient Cosmetic & Whitening Periodontal Implant Sedation Endodontics

Referring Dentist Details

Name: ……………………………………………………………………………………………..

Address: ……………………………………………………………………………………...

Tel: …………………………………………… Fax: ……………………………………………..

Email: ……………………………………………………………………………………………..

Preferred communication method (circle as appropriate) - Letter / Telephone / Fax / Email

Patient Details

Name: ……………………………………………………………………………………………..

Address: ……………………………………………………………………………………...

Tel: ..…………………………………………… Mob: ……………………………………………..

Email: …………………………………………… DOB: ..……………………………………………..

Dentist Objectives

For opinion only For initial discussion with the patient advisor For treatment

Reason for Referral

History of the referred complaint ……………………………………………………………………………

………..

Dental History

Does the patient attend regularly? Is the patient very nervous about treatment?
Is the patient periodontally stable? Is the patient currently having additional dental treatment?

Social History

Does the patient smoke? Does the patient live alone? Does the patient have any relevant physical disabilities?

Any other information

Enclosures (ie radiographs / pocket charting) Are the radiographs to be returned?

Signature…………………………………………. Date……………………………………………