

Referral Form



Wightwick Dental Practice

A Brighter Healthier Smile

Title:	Date of Birth: / /
Forenames:	Home Tel N°:
Surname:	Mobile Tel N°:
Address:	Work Tel N°:
	Email:
City/Town:	Best Time to call:
Postcode:	Date of Referral: / /

Has the patient been referred before? Yes No

Type of referral:

<input type="checkbox"/> Implantology/Prosthodontics	<input type="checkbox"/> Oral Surgery
<input type="checkbox"/> Endodontics	<input type="checkbox"/> OPG/CBCT Scan
<input type="checkbox"/> Periodontology	<input type="checkbox"/> Dental Hygiene Services
	<input type="checkbox"/> Treatment under inhalation sedation

Referral for: Advice Treatment

X-rays enclosed: Yes No

Case study enclosed: Yes No

Referring Practitioner

Title:	Practice Name:
Forename:	Address:
Surname:	Postcode:
Email:	Tel N°:
	Signature:

Our Referral Guarantee

A clinician accepting a patient on referral will only undertake treatment they feel to be appropriate and that which lies within their competency. If the accepting clinician feels that alternative or additional treatment is required, this will be discussed with both the referring clinician and the patient and consent obtained for an amended treatment plan and any costs involved. Unless otherwise agreed with the referring clinician the accepting clinician will only carry out treatment in the capacity for which the patient has been referred to him/her.