# Referral Form

**Complete the form to submit a referral to The Town House Dental Practice**



## Patient Details

**First Name :** _____ **Last Name :** _____

**Date of Birth :** ☐☐ / ☐☐ / ☐☐ **Phone Number :** _____

**Email Address :** _____ **Postcode :** _____

**Address :** _____

## Referral Details

**Location :**

**Referral Service :** ○ Implants ○ Endo (Tunbridge Wells Only) ○ Oral Surgery ○ OPG ○ CBCT ○ Sedation ○ Bone Graft ○ Sinus Lift

○ Brighton & Hove
○ Tunbridge Wells

**Reason for Referral :**

**Relevant Medical & Dental History :**

**Enclosures :** ○ Radiographs ○ Clinical Photos

**Provided By :** ○ Enclosed ○ Post ○ Email

## OPG Details *Leave if not relevant*

**Justification for X-ray :**

○ Implant Treatment Planning ○ Orthodontic Assessment ○ Impacted Teeth Assessment ○ TMJ

○ Endodontic Assessment ○ Other (please specify) _____

**Is the patient possibly pregnant :** ○ Yes ○ No ○ Don't know

**Payment :** ○ Invoice to patient ○ Invoice to dentist

**BRIGHTON & HOVE**
brighton@townhousedentalpractice.co.uk
01752 553318
10 Matlock Road, Brighton & Hove, BN1 5BF

**TUNBRIDGE WELLS**
info@townhousedentalpractice.co.uk
01892 616062
16 Newton Road, Tunbridge Wells, TN1 1RU

**townhousedentalpractice.co.uk**

# Referral Form

**Complete the form to submit a referral to The Town House Dental Practice**



## CBCT Details *Leave if not relevant*

**Select teeth that need to be scanned :**

○ Include TMJs ○ Both Jaws ○ Maxilla (see below) ○ Mandible (see below) ○ Sectional/Quadrant

**Mailla (Upper Jaw) :**

○ 18 ○ 17 ○ 16 ○ 15 ○ 14 ○ 13 ○ 12 ○ 11 ○ 21 ○ 22 ○ 23 ○ 24 ○ 25 ○ 26 ○ 27 ○ 28 ○ ALL

**Mandible (Lower Jaw) :**

○ 48 ○ 47 ○ 46 ○ 45 ○ 44 ○ 43 ○ 42 ○ 41 ○ 31 ○ 32 ○ 33 ○ 34 ○ 35 ○ 36 ○ 37 ○ 38 ○ ALL

**Justification for X-ray :**

○ Implant Treatment Planning ○ Bone Graft ○ Impacted Teeth Assessment ○ TMJ

○ Endodontic Assessment ○ Oral Pathology ○ Orthodontics

○ Other (please specify) _____

**Is there a stent to be fitted?** ○ Yes ○ No

**Is the patient possibly pregnant :** ○ Yes ○ No ○ Don't know

**Format Required :** ○ With viewing software ○ Third party software compatible

**How would you like the scan received?** ○ Disk ○ Electronically

**Payment :** ○ Invoice to patient ○ Invoice to dentist

## Referrer Details

**Referring Clinician:** _____ **GDC Number :** _____

**Dental Practice:** _____ **Phone Number :** _____

**Email Address :** _____ **Postcode :** _____

**Address:** _____

**Date of Referral :** ☐☐ / ☐☐ / ☐☐ **Signature :** _____

**BRIGHTON & HOVE**
brighton@townhousedentalpractice.co.uk
01752 553318
10 Matlock Road, Brighton & Hove, BN1 5BF

**TUNBRIDGE WELLS**
info@townhousedentalpractice.co.uk
01892 616062
16 Newton Road, Tunbridge Wells, TN1 1RU

**townhousedentalpractice.co.uk**