

Referral Form

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



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Patient Details

First Name : **Last Name :**

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

Email Address : **Postcode :**

Address :

Referral Details

Referral Service : Implants Endo (Tunbridge Wells Only) Oral Surgery Brighton & Hove
 OPG CBCT Sedation Bone Graft Sinus Lift 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



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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

Maxilla (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:	<input type="text"/>	GDC Number :	<input type="text"/>
Dental Practice:	<input type="text"/>	Phone Number :	<input type="text"/>
Email Address :	<input type="text"/>	Postcode :	<input type="text"/>
Address:	<input type="text"/>		
Date of Referral :	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	Signature :	<input type="text"/>

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