CAUSEWAY &
BLACKHORSE WAY
DENTAL PRACTICE

Hygienist Referral Form

Patient Information:

☐ Mr ☐ Mrs ☐ Miss ☐ Ms

Surname: Forename: DOB:

Address:

Postcode:

Tel (Primary): Tel (other): E-Mail:

Relevant Medical History (including medications):

Reason for Referral:

☐ Chronic Periodontitis ☐ Chronic Gingivitis ☐ Maintenance

☐ Generalised ☐ Localised

Other:

Special Instructions / requests:

Treatment planned or undertaken:

Radiographs Included? ☐ Yes ☐ No BPE:

Pocket Chart Included? ☐ Yes ☐ No

Referring Dentist:

Name: Practice Address:

Postcode:

Tel: E-Mail:

Signature: Date:

Once you have completed this form, please submit it by post to our practice manager.
All information provided will be treated with the strictest confidence. Thank you.

The Causeway Dental Practice, 8 Causeway, Horsham, West Sussex, RH12 1HE