CAUSEWAY &
BLACKHORSE WAY
DENTAL PRACTICE

Prosthodontic Referral Form

Patient Information:

Title:

Forename:

Surname:

DOB:

Address:

Telephone:

Mobile:

Email:

Medical history:

Medications:

Allergies:

Smoker: YES / NO / PAST
No Per Day : _____

☐ **Implant Assessment** ☐ **Denture Stabilisation with implants** ☐ **Dentures**

☐ **Crown / Bridge** ☐ **Tooth Wear** ☐ **Smile Design / Aligners** ☐ **2nd Opinion**

Diagnosis:

Reason for referral/reason for treatment:

Recent x-ray(s) & photos included: YES / NO **OH:** GOOD / MODERATE / POOR

Is the patient high risk for periodontal disease or caries: PERIO / CARIES / NO

Regular Attender to GDP: YES / NO **Regular Hygiene Attender:** YES / NO

Patient Aware of approximate costs of treatment: YES / NO

Preferred Clinician: YES / NO If Yes please specify _____

Referring dentist:
Address:

Date of Referral:
Telephone:

Office use only:

Actions Needed: _____

_____

Dentist Referral Allocated to: _____

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