The Bay Tree Dental Centre

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Referrals for Oral Surgery

Date: .....

Patient Details:

Surname: ..... First Names: .....

Date of Birth: .....

Address: .....

..... Post Code: .....

Home Phone: ..... Mobile: .....
(or work)

Relevant Medical History:

Reason for Referral:

Have any relevant radiographs been included? Yes / No *(please circle)*

If the referral is for implants, do you wish to carry out the restorative phase? Yes / No *(please circle)*

Referring Dentist Name and Address:

Signature: .....

Many thanks for your referral