

# Referral

Dr Mike Booth BDS VUManc and Dr Marian Vallina BDS Birm. and hygienists.  
Implant, Endodontic, Prosthetic and Peridontal Referral.

## Referring dentist

Name and address \_\_\_\_\_

Date of referral \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

Email \_\_\_\_\_

## Patient details

Name and address \_\_\_\_\_

Telephone number (home , work and mobile) \_\_\_\_\_

Date of birth \_\_\_\_\_

## Relevant Medical History

Please include any relevant radiographs and models which may help in evaluating the patient. These will be returned after use. \_\_\_\_\_

\_\_\_\_\_

## Type of referral (please tick)

Patient new to your practice  Regular attender

## Full perio case assessment

The patient is experiencing - please indicate and provide detail

Pain  Swelling  Bleeding  Bad taste  Recurrent abscesses  Tooth mobility  Difficulty chewing

\_\_\_\_\_

## Isolated perio procedure

Please specify: crown lengthening, guided tissue regeneration, gingival recession.

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Continued