Referral Form

COTTINGHAM
DENTAL PRACTICE

COTTINGHAM HOUSE
190-192 KING STREET
COTTINGHAM
EAST YORKSHIRE HU16 5QJ

TEL: 01482 848655
FAX: 01482 841897

Please complete all of the fields.

Date / /

Dentist details

Referring dentist

Address

Postcode

Telephone Email

Patient details

Title (Mr/Mrs etc) Gender M ☐ F ☐ Name

DoB / / Contact address

Postcode

Contact telephone: Home Work

Mobile Email

Patient's main complaint / dentist's reason for referral

What treatment do you want us to undertake?

We will work to your guidelines. Please complete your instructions on the back of this form – PTO.

Medical history

Name of GP Practice contact number

Relevant medical details

Clinical details

Rads enclosed? OPG Y / N PAs Y / N

Others

Further details (eg special requests by patient or referring dentist)

Please fax (01482 841897) or post this form back to Cottingham Dental Practice. Thank you.

Treatment limitations

We will provide treatment to the level you request:

Please tick the relevant box

Consultation and treatment plan only (will include relevant radiographs)	☐

Endodontics

Endodontics treatment only	☐
Endodontics treatment and core (if appropriate)	☐
Endodontics treatment, core and restoration preparation with temporary restorations	☐
Endodontic treatment, core and final restoration	☐

Implants

Implant placement only	☐
Implant placements with transmucosal healing former	☐
Implant placement and restoration	☐

Other

Please specify:

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