**Patient Referral Form**



*Coulsdon Dental Clinic*

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SPECIALIST ORAL SURGEON

Dr Mohammed Dungarwalla BDS(Hons) MFDS RCS(Ed) MSc PGCert(MedEd PGCert(ClinRes) MOralSurg(RCSEd)

|  |
| --- |
| Patient Details |
| Title |  |
| First Name |  |
| Surname |  |
| DOB |  |
| Tel (Home) |  |
| Tel (Mobile |  |
| Address |  |
| Email |  |

|  |
| --- |
| Reason for Referral |
| Consultation RequiredDirect to Treatment*Please tick any that apply*ConsultationCBCT ScanRoutine ExtractionSurgical ExtractionWisdom Tooth ExtractionCoronectomyExposure and BondBiopsy (Including report)Fraenectomy1 2 3 4 5 6 7 88 7 6 5 4 3 2 11 2 3 4 5 6 7 88 7 6 5 4 3 2 1Comments:  |
| Clinical Details of Patient |
| Condition being referred |  |
| Does Patient take Anticoagulants |  |
| Does Patient take Bisphosphonates |  |
| Has patient received radiotherapy to the head and neck region |  |
| Allergies |  |
| Preference for LA or Sedation |  |
| Any other information  |  |

|  |
| --- |
| Referring Practitioner |
| Dentist Name |  |
| Practice Name |  |
| Practice Address |  |
| Date |  |
| Tel |  |

We will contact patients directly to make an appointment. Many thanks for your Referral.