Referral Form

COTTINGHAM
DENTAL PRACTICE

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

TEL: 01482 848655

Please complete all of the fields.

Date / /

Dentist details

Referring dentist

Address

Postcode

Telephone Email

Patient details

Title (Mr/Mrs etc) 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 scan/email (robert.nichols1@nhs.net) 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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