LOVAT HOUSE DENTAL
SPECIALIST, IMPLANT & AESTHETIC CARE

32 Christ Church Road, Cheltenham,
Gloucestershire, GL50 2PL

ORAL SURGERY REFERRAL FORM

Patient details:

Name:	**DoB:** DD / MM / YYYY	**Male** ❑	**Female** ❑
Address: **Postcode:**			
Home Tel:	**Work Tel:**	**Mobile Tel:**	
Treatment requested, with diagnosis, and details of consideration of other treatment options:			
All medical conditions, allergies/reactions and medications:			

Radiographs

To prevent unnecessary re-exposure to ionising radiation, please enclose any appropriate radiographs with your referral. Radiographs must be labelled with the patient name, date of birth and date of exposure. Digital radiographs can be sent on CD or by secure email to reception@lovathousedental.co.uk

Radiographs included? **Yes** ❑ **No** ❑ **N/A** ❑
If **YES**, please state type:

Other information

Please describe any mobility or communication issues relevant to the patient's treatment

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Referring Dentist

Name, signature and address of referring dentist	**Date:** DD / MM /YYYY
Print name:	**Signature:**
Address:	