Please be assured that we will neither approach nor accept your patient for non-referred treatment.

Periodontal Referral **Form**

Referring Practitioner's Details:

Name ______________________

Address ______________________

____

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Contact Number ______________________

Patient Details:

Name ______________________

Date of Birth ______________________

Address ______________________

____

____

Home Telephone ______________________

Mobile Telephone ______________________

Work Telephone ______________________

Email ______________________

Please confirm copies of relevant Radiographs/Chartings Enclosed: Yes ○ No ○

Date:

Chief Concern:

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Other Periodontal Findings/Treatment:

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Relevant Medical History:

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Smoker Yes ○ No ○ **Year Quit** ________

How Many Daily ________ **Years of Use** ________

BPE

Please note any teeth with mobility:

85 – 87 Strand Road, Derry, BT48 7NW
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