Prosthodontic Referral Form

Charing Cross Practice

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Referring Colleague

Name.....

Address.....

.....

Contact Tel. No.....E-mail:.....

Patients Details

Name.....

Address.....

.....

Contact Tel. No.....Date of birth.....

E-mail:.....

Relevant medical history.....

.....

Clinical Details

Main complaint/ reason for referral.....

.....

..... ADVICE ONLY ☐ TREATMENT ☐

Type of treatment required (*e.g.* Partial/ complete denture; management of tooth surface loss)

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Prostheses worn, if any:.....

Particular treatment difficulties (*e.g.* Dry mouth, gagging, anatomical) .....

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PLEASE ASK YOU PATIENT TO BRING ANY PROSTHESES WITH THEM (SATISFACTORY OR NOT) WHEN THEY ATTEND THEIR CONSULTATION