NOVOCARE
DENTAL

Referral Form

Referring Dental Practice

Practice Name: _____
Referring Clinician: _____
GDC No.: _____
Phone: _____
Email:_____
Practice Address: _____

Patient Details

Full Name: _____
Date of Birth: _____
Phone: _____
Email: _____
Address: _____

Referral Information

Urgency: [ ] Routine [ ] Urgent (24-72h)

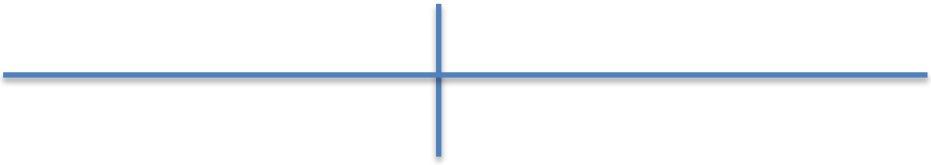
Specialty (tick all that apply):

[ ] Endodontics [ ] Oral Surgery [ ] Implants [ ] Sedation [ ] Restorative
[ ] Prosthodontics

Reason for Referral:

_____
_____
_____

Tooth/Area Involved (list teeth or use diagram if applicable):

R  **L**

_____

Investigation/Treatment Requested:

Radiography:

[ ]OPG [ ] CBCT

Endodontics:

[ ] Assessment only [ ] Root Canal Treatment [ ] Post placement
[ ]Retreatment

Oral Surgery:

[ ] Extraction (Surgical/Wisdom) [ ] Bone graft [ ] Soft tissue surgery (e.g. frenectomy)
[ ] Apicectomy

Implants:

[ ] Implant planning [ ] Implant placement [ ] Restoration of implant

Sedation:

[ ] IV sedation for routine treatment [ ] Sedation assessment only

Restorative:

[ ] Composite restoration [ ] Crown / Onlay [ ] Bridge [ ] Full Mouth Rehabilitation

Prosthodontics:

[ ] Complete dentures [ ] Partial dentures [ ] Implant-retained prosthesis
[ ] Occlusal rehabilitation

Relevant Medical/Dental History:

_____
_____
_____

Supporting Information:

[ ] Radiographs included [ ] Clinical photos included [ ] CBCT scan included

Follow-up Preference:

[ ] Contact patient directly [ ] Contact referring dentist [ ] Report back after assessment [ ] Treatment only if accepted by patient

Referring Clinician Signature: _____ Date: _____

Please send to Novocare Dental, 32 The Avenue, Watford, WD17 4NS