HAZELWOOD
DENTAL PRACTICE

Thank You For Your Referral
For more information see our website
www.hazelwood-dental.com/refer

Alternatively you can fill in the form below and post it to us to commence your referral (Please retain a copy for your records)

1 Complaint / Treatment Required

- ☐ Implants
- ☐ Root Canal
- ☐ Oral Surgery
- ☐ Sedation
- ☐ Invisalign
- ☐ OPG

2 Please fill in the fill details of the treatment requested / Justification for radiograph / Area of interest

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3 Patients Details

Name ______________________________

D.O.B. ____________________ Sex ________

Address ______________________________

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Tel No. ______________________________

Mobile ______________________________

Email ______________________________

4 Please state what has been enclosed

- ☐ X-Rays
- ☐ Casts
- ☐ Medical History Sheet
- ☐ Other ______________________________

5 Medical History (Pregnancy for OPG)

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6 Referring Dentist

Dentist Name ______________________________

Practice Name ______________________________

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Address ______________________________

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Tel No. ______________________________

Fax No. ______________________________

Mobile ______________________________

Email ______________________________

Please indicate for OPG if you would like:

- ☐ Print out
- ☐ Return by secure email

7 Do you require more referral forms?

- ☐ Yes
- ☐ No

Signature of referring dentist:

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GDC No. ______________ Date ______________