HAZELWOOD DENTAL PRACTICE

Thank You For Your Referral

For more information see our website

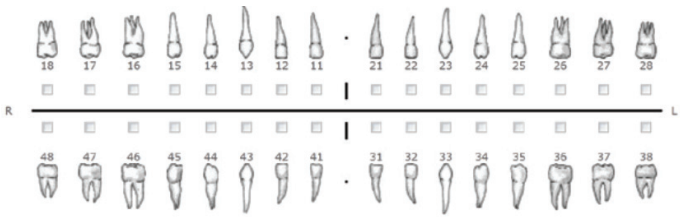
www.hazelwood-dental.com/refer

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

1 Treatment Required

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

2 Please fill in the full details of the treatment requested / Justification for radiograph / Area of interest (mandatory)



(If no teeth are selected the whole jaw will be scanned)

3 Patient Details

Title _____

Name _____

D.O.B. _____

Address _____

_____

Tel No. _____

Mobile _____

Email _____

4 Please state what has been enclosed

- ☐ X-Rays
- ☐ Other
- ☐ Medical History Sheet
- ☐ Casts
- ☐ Are they bringing own Radiographic template?

5 Is there a possibility of pregnancy for OPG/CBCT? (Mandatory)

- ☐ YES
- ☐ NO

6 Medical History

_____

_____

7 Referring Dentist

Dentist Name _____

Practice Name _____

Address _____

_____

Tel No. _____

Mobile _____

Email _____

Please provide secure email for return of images

_____

8 Do you require more referral forms?

- ☐ YES
- ☐ NO

_____

Signature of referring dentist

_____ _____

GDC No. *Date*

**By Sending this ref you agree to our standard T&C's*

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