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SKERRIES
DENTAL CARE

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Patient Referral Form

Referring Dentist
Contacts/Stamp

Patient's details

First Name: _____ Surname: _____

DOB: ____/____/____

Address: _____

Mobile No: _____ Home No: _____

Tooth Number: _____ **Radiographs enclosed :** _____

Short description of the problem, patient is referred for: _____

_____

_____

Treatment required:

- Consultation only ☐
- Root canal therapy ☐
- Endodontic surgery ☐

Restoration required:

- Core build up (Composite or Amalgam) ☐
- Post space ☐
- Post & core (Fibre post & composite build up) ☐

Important medical history requirement

Allergic to _____

Other precautions _____

Additional information:

Urgent ☐ Limited opening ☐ Previously accessed ☐ Perforation ☐

Other comments _____

_____