escentics
dental & implant centre

patient referral form

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E: info@escentics.com
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Practitioner Details:	Patient Details:
Referring Dentist	Surname
Practice Name	First Name/s
Address	Address
Postcode	Postcode
Telephone	Tel: Home
Email	Mobile
Date of Referral	Email
Signature	Date of Birth
	Sex Male ☐ Female ☐

REASON FOR REFERRAL: ☐ **OPINION** ☐ **TREATMENT**

- ☐ Implants ☐ Endodontics ☐ Prosthodontics
- ☐ Oral Surgery ☐ Oral Hygiene ☐ Sedation
- ☐ Facial Aesthetics Fillers/ Wrinkle Reduction ☐ Periodontics BPE Chart:

TOOTH NOTATION:

MAIN COMPLAINT / REASON FOR REFERRAL:

Has the patient given informed consent to Diagnostic & Referral Procedure? **Yes** ☐ **No** ☐

RELEVANT MEDICAL HISTORY:

Special Access Required Yes ☐ No ☐

ENCLOSURES:

☐ Radiographs ☐ Medical History Form ☐ Study Models ☐ Accompanying Letter

☐ Email Radiographs to **info@escentics.com** **REFERENCE NUMBER**_____

Please use a REFERENCE NUMBER for all correspondence to identify your patient.

OFFICE USE:	**Received by:**	**Date:**	**1st Appt Date:**
Confirm GDP:	**Confirm PT:**	**Completion GDP:**	**Review (Mth/Yr):**