

**Referral form**; the completed form can be sent in post, alternatively please download (pdf or Word) and email the completed electronic copy to:

joanne@oxfordplacedental.co.uk

Date: ……/……/20…..

Please indicate the referral service you require (for CBCT, please use the separate form and agreement):

* Implants
* Sedation; please note patients should be aged 16-60 years with no or well controlled systemic diseases.
* Orthodontics
* OPG/Lat Ceph

Referring dentist: Dr ………………………

Practice: …………………………………..

* ……………………………….
* …………………………………………….

Patient’s name: …………………………..

DOB: ……/……/………

Address: ………………………………………………………………………………….

* ……………………….
* ……………………………………………..

Reason for referral:

Medical history and medications:

Patient’s radiographs included or available on request: …………………………………..

* Please tick if you wish these to be sent back to you.

For any questions, please email Joanne or ring on: 01229825854

Many thanks for you referral;

The team at OXFORD PLACE DENTAL