Dr. Najeeb Hussain

ORAL SURGERY REFERRAL FORM

Morden Smiles

PRACTITIONER AND PRACTICE DETAILS:

Name of Practitioner

Practice Name

Address

Telephone

Email

PATIENT DETAILS:

Title **DOB**

Name

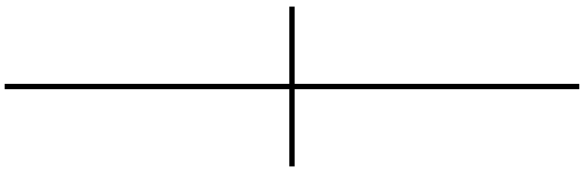
Address

Telephone

Email

MEDICAL HISTORY

TREATMENT REQUIRED (details):



REASON FOR REFERRAL:

- ☐ EXTRACTION(S) TOOTH
- ☐ EXTRACTION(S) RETAINED ROOTS
- ☐ WISDOM TOOTH REMOVAL
- ☐ ALVEOPLASTY
- ☐ INCISION/DRAINAGE
- ☐ APICECTOMY
- ☐ PERI-IMPLANTITIS
- ☐ EXPOSE AND BOND
- ☐ SOFT TISSUE LESION REMOVAL/BIOPSY
- ☐ BONE GRAFTING
- ☐ FRENECTOMY
- ☐ SINUS GRAFT
- ☐ SECOND OPINION (details):
- ☐ OTHER (details):

☐ ADULT ☐ PAEDIATRIC

URGENT? ☐ YES ☐ NO

TREATMENT UNDER: ☐ LA ☐ IV SEDATION

PLEASE TAKE: ☐ OPG ☐ CT SCAN ☐ PERI-APICAL ☐ OTHER

☐ TREATMENT PLAN AGREED WITH PATIENT ☐ APPROPRIATE RADIOGRAPHS ENCLOSED

Signed by Dentist:…… **Date:**……..

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