Affinity Dental Care & Implant Centre

Referral Form

Date: _____

Referral Requirements *(please circle all the apply):* Oral Surgery Dental Implants TMJ/TMD
Surgical / Complex Surgical Extractions Oral Mucosal Lesions Facial Pain
Pin Hole Surgical Technique for gum recession Adult Braces/ orthodontics
X-rays (OPG/ CBCT Scan /OPT) Bio Clear / Cosmetic Treatment
Laser Perio Treatment Laser treatments (e.g. tongue tie, frenectomy) Snoring/Sleep Apnoea OSA

Referring Dentist Details:

Name and Practice Address: _____

_____ Post Code: _____

Telephone: _____ Mobile: _____

Email _____

Patient Details:

Name: _____ Title: _____

Address: _____

_____ Post Code: _____

Telephone: _____ Mobile: _____

Email: _____

Date of Birth: _____

Referral Information *(please include reason for referral and particular problem area along with x-rays & photos):* _____

_____

_____

Medical History *(please include any relevant information regarding the patient's medical history)*:

_____

_____

_____

Affinity Dental Care & Implant Centre
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