

391 Wickham Road, Croydon, CRO 8DP PHONE 020 8777 2040, EMAIL referrals@gentledentalcaregroup.co.uk

Standard of care - We will aim to contact your patient within 48 hours, and book a consultation within 2 weeks.

Please tic	k writer service you	u re referring your p	Datient for						
Implant	Periodontics	Endodontics	Prosth	odontics	Oral Surger	Oral Surgery		Sedation + Treatment	
REFERRIN	G DENTIST DETAILS	Date of referra	al /	/	Date referral re	ceived	/	/	
Full Name:	Mr/Mrs/Miss/Ms/Dr/P	Prof:							
Tel:			Email:						
PATIENT D	DETAILS								
Surname:			Forenames:						
Address:									
				Postcode:		DOB:	/	/	
Tel:			Email:						
REFERRAL SUMMARY (e.g. reason for referral, specific problem areas, details of patient awareness & future plan for treatment etc)									
RELEVAN	MEDICAL HISTOR	Y							
ENCLOSU	RE DETAILS								