Ian Cross

SPECIALIST ENDODONTIST & PROSTHODONTIST

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Referral form

_____20____

Root Canal Work ☐ **Restorative Work** ☐

PATIENT DETAILS

Name _____

Sex M / F DOB _____ /_____ /_____

Address _____

_____

_____ Postcode _____

Tel No: Home _____ Work _____ Mobile _____

REFERRAL REASON

_____

_____

_____

_____

HISTORY OF PRESENT COMPLAINT

_____

_____

_____

_____

RELEVANT MEDICAL HISTORY/ inc. medications/allergies

_____

_____

_____

Any treatment carried out already (It would be helpful if a radiograph is forwarded with this form)

_____

_____

_____

Other relevant information

_____

_____

_____

Signature _____ Name (CAPS) _____

Referring GDP Details: GDP Address _____

_____

_____

GDP Tel No: _____ GDP Email: _____