**ENDODONTIC REFERRAL FORM**

|  |
| --- |
| **PATIENT DETAILS** |
| Patients Title and Name | Age of patient in years | Sex | Date of Birth (DD/MM/YY) |
| Patient Address |
| Mobile Telephone Number | Home Telephone Number | E-mail address |
| **REFERRAL INFORMATION** |
| Referring Dentist Name | Referring Dental Practice |
| GDC Number of referring dentist | Date of decision to refer |
| **RADIOGRAPHS** |
| I can confirm diagnostically acceptable radiographs, clearly showing the apex of the roots have been sent with this referral Bitewings Periapical OPG None (reason required) Reason if no radiographs........................................................................................................................................... |
| **TREATMENT REQUESTED** |
| Persistent signs/symptoms following RCT Complicated medical history eg restricted mouth opening Difficult root morphology eg curvature of canals Peri radicular or apical surgeryToothFractures, cracks, root resorption, perforations Re-root treatmentOther (please detail)Brief description of treatment required:......................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................... |
| **ADDITIONAL INFORMATION** |
| Relevant medical information, ie medication including dosages, allergies etc | Is the patient a smoker?Yes No |
| **PATIENT CONSENT TO REFERRAL** |
| Has the patient understood and consented to the referral? Yes No | Is the patient aware of the £100 assessment fee?  Yes No  |
| **CONFIRMATION AND SIGNATURE OF REFERRING DENTAL PRACTITIONER** |
| Print Full Name..............................................................................................Signature...................................................................................................... | Date.......................................... |

Please send all referrals to the following address:

Referral Centre

Alchemy Dental Practice

203 Edleston Road

Crewe

Cheshire

CW2 7HT

Telephone: 01270211171

Alternatively, referral forms can be emailed using the email address: tco@alchemydental.co.uk with ‘External Referrer’ in the subject line.

Appointments will be allocated dependent upon need and availability