Practice Referral Form

Discipline(s) Referring to:

- ☐ Oral Surgery
- ☐ Endodontics
- ☐ Orthodontics
- ☐ IV Sedation (as part of above treatments)

Referring Dentist Details:

Title: ____________ Name: ____________

Practice Name & Address: ____________

Practice Postcode: ____________ Practice Tel: ____________

Mobile No: ____________ Email Address: ____________

Patient Details:

Title: ____________ Name: ____________

Address: ____________

Postcode: ____________ Tel: ____________

Mobile No: ____________ Email Address: ____________

Relevant Medical History:

Does the Patient Smoke? ☐ Yes ☐ No

Reason for Referral (Including any treatment already undertaken, and relevant case history. Please include further details on the back of this form if required):

Current Medication:

Please include all relevant radiographs when referring

Signature: ____________ Date: ____________

Once completed, please send your referral via email to referrals@hamptondental.co.uk

Hampton Dental Care, 2nd Floor, 28 Argyle Street, Liverpool, L1 5DL
Tel: 0151 295 9870 Email: referrals@hamptondental.co.uk