WAPPING DENTAL CENTRE

172 The Highway, London, E1W 3DD
Tel 020 7481 1013
www.wappingdentalcentre.com

PRIVATE DENTAL HYGIENIST REFERRAL FORM

Referral Date ……/……/……

Practice Name & Address ……
……
……
……

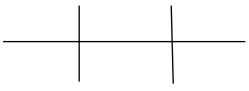
Telephone Number ……
Name of Referring Dentist ……
Signature of Referring Dentist ……

Patient Details

Name Mr/Mrs/Miss/Ms ……
Address ……
……
……Postcode……
Telephone ……
Date of Birth ……/……/……
Medical History & Medications ……
(including allergies etc) ……
Please continue on reverse if required

Referral Details

BPE



Please provide LA as required (please check mh) ☐
Please provide hygiene treatment as required ☐
Please provide hygiene care as per treatment plan below ☐

Any further relevant information ……
……
……
……

Please forward any relevant radiographs and 6ppc for any quadrants BPE 3 or 4

THANK YOU FOR YOUR REFERRAL