# DENTAL REFERRAL FORM

## The Dental Studios

398 Victoria Road, G42 8YP Glasgow, United Kingdom
Phone: 0141 423 6106 | Email: reception@thedentalstudios.org

## REFERRING DENTIST INFORMATION

**Dentist's Full Name: ***

**GDC Number: ***

**Contact Phone: ***

**Contact Email: ***

**Dental Practice Address: ***

**Referral Type: * (Please tick one)**

- ☐ **Oral Surgery** — Complex extractions, apicoectomy, biopsies, cancer referrals
- ☐ **Endodontics** — Complex root canal treatments or re-treatments
- ☐ **Restorative/Prosthodontics** — Complex crowns, bridges, full-mouth reconstruction
- ☐ **Sedation Referrals** — Inhalation or intravenous sedation needed
- ☐ **Orthodontics** — Malocclusions or tooth alignment assessment
- ☐ **Periodontics** — Advanced gum disease, periodontal surgery, implants
- ☐ **Special Care Dentistry** — Patients requiring special care (medical histories/phobias)
- ☐ **Diagnostic Imaging** — Specialized scans (CBCT)

## PATIENT INFORMATION

**Patient's Full Name: ***

**Patient's Phone: ***

**Patient's Address: ***

**Date of Birth: ***

Day: _____ Month: _____ Year: _____

## MEDICAL & TREATMENT INFORMATION

**Current Medication:**

**Allergies:**

**Treatment(s) Required: * (Please tick all that apply)**

- ☐ Oral Surgery
- ☐ Tooth Alignment
- ☐ Veneers & Crowns
- ☐ Fixed Braces
- ☐ Implants & Missing Teeth

**Patient's Medical History: ***

**If extraction: is prosthesis planned? ***

○ Yes ○ No

**Is IV sedation needed? ***

○ Yes ○ No

Referring Dentist Signature: _____ Date: _____

**How to Submit This Form:**

Email: reception@thedentalstudios.org | Phone: 0141 423 6106

For urgent referrals, please call us directly.

We will review your referral within 24-48 hours and contact the patient to schedule an appointment.