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.