

Dental External Referral Form

Patient Name	:	Ayesha Saif Al Gurair	Emirates ID	:	999-9999-999999-9
File No	:	1142	DOB	:	1980-01-01
Nationality	:	Emirati			
Gender	:	Female	Doctor's Name	:	Dr Nadir El Tayeb
Date	:	2024-05-30			

FULL NAME::Ayesha Saif Al Gurair CONTACT NO.:5053559000 AGE :44

Referring Healthcare professional : Dr Nadir El Tayeb

☒ Emergent (send patient to ED)
 ☒ Urgent (24-72 hours)
 ☐ Routine (next available)

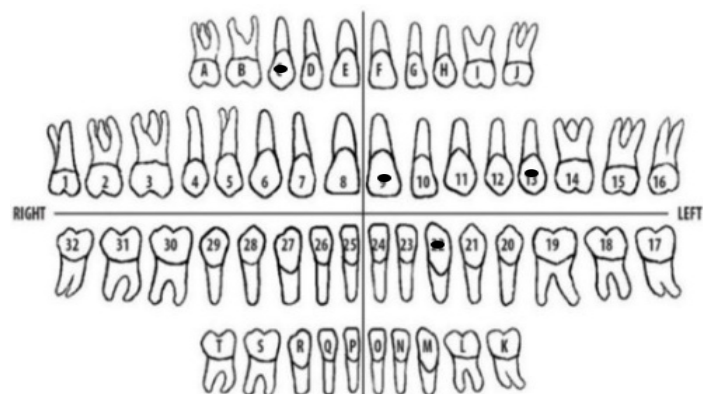
Interpreter needed: ☐ YES ☐ No

☐ X-rays emailed
 ☐ X-rays with patient
 ☐ Need X-rays (please send X-rays to info@yoland.com)


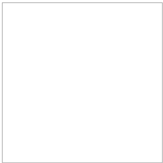
Reason for Referral: ☐ Consultation ☒ radion

EXAMINATION:

<input type="checkbox"/> Comprehensive care	<input type="checkbox"/> Endo:RCT only	<input type="checkbox"/> Extractions
<input type="checkbox"/> Crowns	<input type="checkbox"/> Endo:RCT,Permanent Restoration/Crown	<input type="checkbox"/> Sedation
<input type="checkbox"/> Bridges	<input type="checkbox"/> Periodontal Care	<input type="checkbox"/> Special needs(specify type):
Patents:	<input checked="" type="checkbox"/> verbal	<input checked="" type="checkbox"/> Non verbal
<input type="checkbox"/> Denture: Complete	<input type="checkbox"/> Implants: Surgical only	<input type="checkbox"/> Denture: Partial
<input type="checkbox"/> Implants:Surgical and Restorative	<input type="checkbox"/> Denture: Overdenture	<input type="checkbox"/> Orthodontic care
<input type="checkbox"/> Complex medical needs:	<input type="checkbox"/> Please provide written report via Email	



Evaluated by :Dr Nadir El Tayeb

Sign here, only if all of your questions have been answered to your satisfaction	
PATIENT	DOCTOR
	
Patient Name Ayesha Saif Al Gurair Date 2024-05-30 (13:30 - 15:00)	Doctor Name Dr Nadir El Tayeb - Dental (DHA-T-00171042) Date 2024-05-30 (13:30 - 15:00)