

## Dental External Referral Form

Patient Name	:	SHAAD SAIF ALSHAB			Emirates ID	:	784-2001-2604273-6	
File No	:	8267	DOB	:	2001-07-26	Nationality	:	Other
Gender	:	Female	Doctor's Name	:	Dr Nadir El Tayeb	Date	:	2024-06-03

FULL NAME:: SHAAD

CONTACT NO.:971503380880

AGE :22

Referring Healthcare professional : Dr Nadir El Tayeb

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

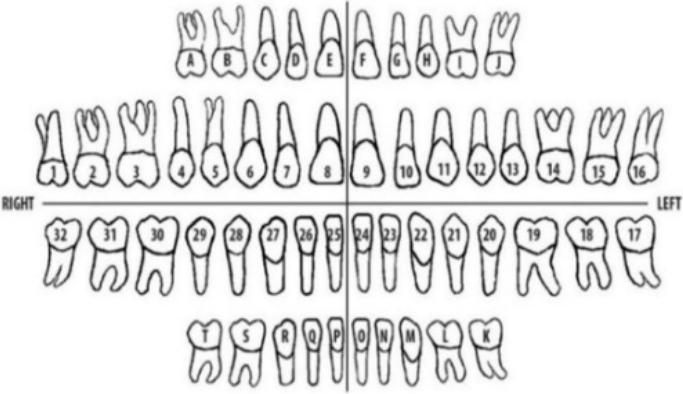
Interpreter needed: ☐ YES ☒ No

☒ X-rays emailed ☐ X-rays with patient ☒ Need X-rays (please send X-rays to [â€|â€|.yoland.com](mailto:â€|â€|.yoland.com))

Reason for Referral: ☐ Consultation ☐ radion

- ☐ Comprehensive care
- ☐ Crowns
- ☐ Bridges
- ☐ Denture: Complete
- ☒ Denture: Partial
- ☒ Denture: Overdenture
- ☐ Complex medical needs
- ☐ endo: rct only
- ☐ endo: rct, permanent restoration/crown
- ☐ periodontal care
- ☐ implants: surgical only
- ☒ implants: surgical and restorative
- ☒ orthodontic care

- ☐ extractions
- ☐ sedation
- ☐ special needs (specify type):



☐ Please provide written report via Email

Sign here, only if all of your questions have been answered to your satisfaction	
PATIENT	DOCTOR
	<div></div>
Patient Name SHAAD SAIF ALSHAB  Date 2024-06-03 (12:00 - 12:15 )	Doctor Name Dr Nadir El Tayeb - Dental (DHA-T-00171042)  Date 2024-06-03 (12:00 - 12:15 )