

Dental External Referral Form								
Patient Name	:	khloud sharfi				Emirates ID	:	
File No	:	8286	DOB	:	1900-01-01	Nationality	:	Indian
Gender	:	Male	Doctor's Name	:	Dr Nadir El Tayeb	Date	:	2024-06-05

FULL NAME:: khloud CONTACT NO.:50 650 9950 AGE :124

Referring Healthcare professional : Dr Nadir El Tayeb

This Referral is:

☒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 khouda.yoland.com)

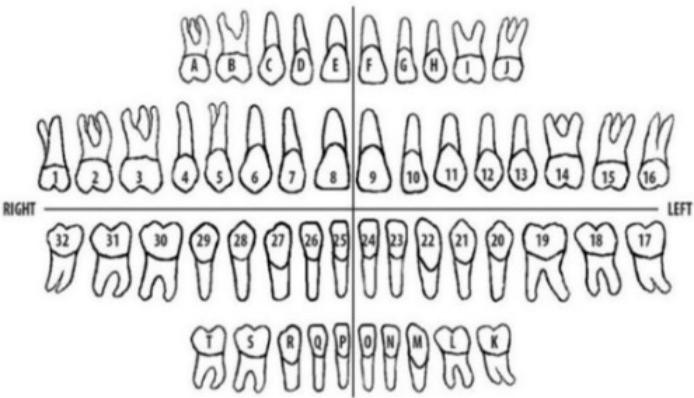
Reason for Referral:

☒Consultation ☐radion


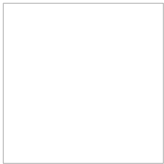
- ☐Comprehensivecare
- ☒ Endo: RCT only
- ☒ Extractions
- ☐ Crowns
- ☒Endo:RCT,Permanent Restoration/Crown
- ☒ Sedation
- ☐ Bridges
- ☒Periodontal Care
- ☐ Special needs (specify type):
- ☐ Denture:Complete
- ☒ Implants: Surgical only
- ☐ Denture: Partial
- ☐Implants:Surgical Restorative
- ☐ Denture:Overdenture
- ☐ Orthodontic care
- ☐ Complex medical needs

Patients:

☐Verbal ☐Non-verbal



☐ Please provide written report via Email

Sign here, only if all of your questions have been answered to your satisfaction	
PATIENT	DOCTOR
	

<div>Patient Name</div> <div>khlood sharfi</div> <div>Date</div> <div>2024-06-05 (11:30 - 11:45)</div>	<div>Doctor Name</div> <div>Dr Nadir El Tayeb - Dental (DHA-T-00171042)</div> <div>Date</div> <div>2024-06-05 (11:30 - 11:45)</div>
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