

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	:	2024-06-03

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

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)

Reason for Referral: ☐Consultation ☐radion

☐ Comprehensive care ☐ Crowns ☐ Bridges ☐ Denture: Complete ☐ Denture: Partial ☐ Denture: Complex Overdenture medical needs

☐ endo: rct only ☐ endo: permanent restoration/crown rct, ☒ care ☐ periodontal 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 khloud sharfi  Date 2024-06-03 (13:45 - 14:45 )	Doctor Name Dr Nadir El Tayeb - Dental (DHA-T-00171042)  Date 2024-06-03 (13:45 - 14:45 )