# Dental External Referral Form

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|---|---|---|---|---|---|---|---|---|
| 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)

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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 |
| | |
| Patient Name<br>khloud sharfi<br><br>Date<br>2024-06-03 (15:15 - 15:45 ) | Doctor Name<br>Dr Nadir El Tayeb - Dental (DHA-T-00171042)<br><br>Date<br>2024-06-03 (15:15 - 15:45 ) |