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	:	2024-05-29

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)

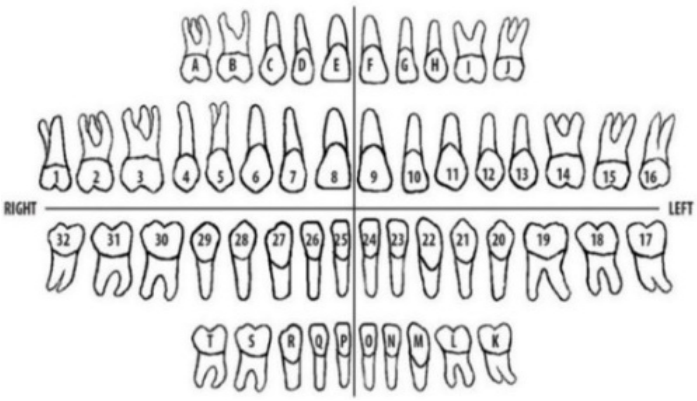
Interpreter needed: ○YES ○No

☐X-rays emailed ☐X-rays with patient ☐Need X-rays (please send X-rays to â€¦â€¦.yoland.com)

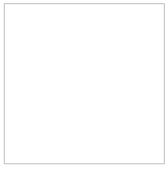
Reason for Referral: ○Consultation ◉radion

EXAMINATION:

☐Comprehensive care	☐Endo:RCT only	☐Extractions
☐Crowns	☐Endo:RCT,Permanent Restoration/Crown	☐Sedation
☐Bridges	☐Periodontal Care	☐Special needs(specify type):
Patents:	☑verbal	☑Non verbal
☐Denture: Complete	☐Implants: Surgical only	☐Denture: Partial
☐Implants:Surgical and Restorative	☐Denture: Overdenture	☐Orthodontic care
☐Complex medical needs:	☐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 SHAAD SAIF ALSHAB Date 2024-05-29 (08:00 - 08:15)	Doctor Name Dr Nadir El Tayeb - Dental (DHA-T-00171042) Date 2024-05-29 (08:00 - 08:15)