

Dental External Referral Form

Patient Name : Halimah Salem Abdallah Almarashdah (dr narmeen) Emirates ID : 999-9999-999999-9
File No : 6864 DOB : 1980-09-11 Nationality : Emirati
Gender : Female Doctor's Name : Dr Nadir El Tayeb Date : 2024-06-15

FULL NAME : Halimah Salem Abdallah Almarashdah (dr narmeen)

CONTACT NO. : 5519042222 AGE : 43

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 â€¦@yoland.com)

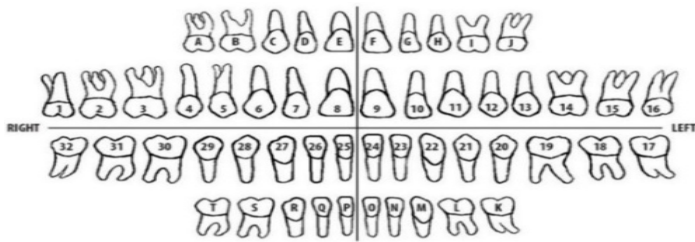
Reason for Referral:

☒ Consultation ☐ radion

- | | | |
|--|--|--|
| <input type="checkbox"/> Comprehensivecare | <input checked="" type="checkbox"/> Endo: RCT only | <input type="checkbox"/> Extractions |
| <input type="checkbox"/> Crowns | <input checked="" type="checkbox"/> Endo: RCT, Permanent Restoration/Crown | <input type="checkbox"/> Sedation |
| <input type="checkbox"/> Bridges | <input checked="" type="checkbox"/> Periodontal Care | <input type="checkbox"/> Special needs (specify type): |
| <input type="checkbox"/> Denture: Complete | <input checked="" type="checkbox"/> Implants: Surgical only | |
| <input checked="" type="checkbox"/> Denture: Partial | <input type="checkbox"/> Implants: Surgical Restorative | |
| <input checked="" type="checkbox"/> Denture: Overdenture | <input type="checkbox"/> Orthodontic care | |
| <input type="checkbox"/> 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



Patient Name
Halimah Salem Abdallah Almarashdah (dr narmeen)

Date
2024-06-15 (14:00 - 15:15)

Doctor Name
Dr Nadir El Tayeb - Dental (DHA-T-00171042)

Date
2024-06-15 (14:00 - 15:15)

