

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

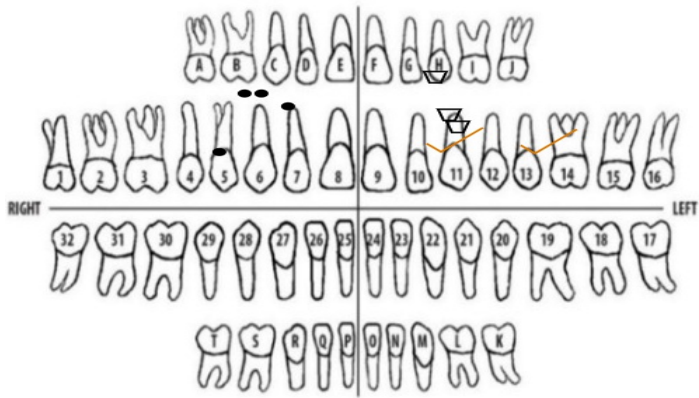
☒Emergent (send patient to ED) ☐Urgent (24-72 hours) ☐Routine (next available)

Interpreter needed: ☐YES ☒No

☒X-rays emailed ☒X-rays with patient ☐Need X-rays (please send X-rays to [â€|â€|.yoland.com](mailto:â€|â€|.yoland.com))

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
	<div></div>
Patient Name khlood sharfi  Date 2024-06-03 (14:00 - 14:15 )	Doctor Name Dr Nadir El Tayeb - Dental (DHA-T-00171042)  Date 2024-06-03 (14:00 - 14:15 )