

Dental External Referral Form

| | | | | | | | | |
|--------------|---|-------------------|---------------|---|-------------------|-------------|--------------------|------------|
| Patient Name | : | ABDOLFATAH BAHMAN | | | Emirates ID | : | 784-1983-4327175-9 | |
| File No | : | 8263 | DOB | : | 1983-04-21 | Nationality | : | Iranian |
| Gender | : | Male | Doctor's Name | : | Dr Nadir El Tayeb | Date | : | 2024-05-24 |

FULL NAME::ABDOLFATAH CONTACT NO.:971555594955 AGE :41

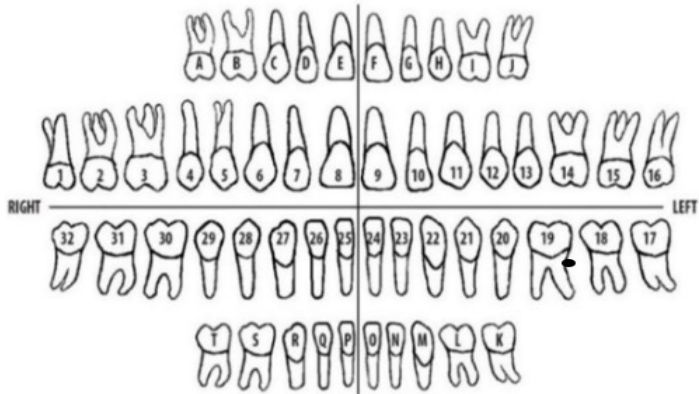
Referring Healthcare professional : Dr Nadir El Tayeb

| PROPHYLACTIC | THERAPEUTIC |
|-------------------------|-------------|
| Complex medical needs:: | |

EXAMINATION:

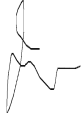

| | | |
|---|--|--|
| <input type="checkbox"/> X-rays emailed | <input type="checkbox"/> X-rays with patient | <input type="checkbox"/> Need X-rays (please send X-rays to â€¦@.yoland.com) |
| <input type="checkbox"/> Comprehensive care | <input type="checkbox"/> Endo:RCT only | <input checked="" type="checkbox"/> Extractions |
| <input type="checkbox"/> Crowns | <input type="checkbox"/> Endo:RCT,Permanent Restoration/Crown | <input checked="" type="checkbox"/> Sedation |
| <input checked="" type="checkbox"/> Bridges | <input type="checkbox"/> Periodontal Care | <input type="checkbox"/> Special needs(specify type): |
| <input type="checkbox"/> Denture: Complete | <input type="checkbox"/> Implants: Surgical only | <input type="checkbox"/> Denture: Partial |
| <input checked="" type="checkbox"/> Implants:Surgical and Restorative | <input type="checkbox"/> Denture: Overdenture | <input type="checkbox"/> Orthodontic care |
| <input type="checkbox"/> Complex medical needs: | <input type="checkbox"/> Please provide written report via Email | |

Reason for Consultation ☐ radion Interpreter needed:: ☐ YES ☐ No Patient is ☒ verbal ☒ non-verbal



Evaluated by :Dr Nadir El Tayeb

| | |
|--|--------|
| Sign here, only if all of your questions have been answered to your satisfaction | |
| PATIENT | DOCTOR |

| | |
|---|--|
|  |  |
| <div>Patient Name</div> <div>ABDOLFATAH BAHMAN</div> <div>Date</div> <div>2024-05-24 (09:00 - 09:15)</div> | <div>Doctor Name</div> <div>Dr Nadir El Tayeb - Dental (DHA-T-00171042)</div> <div>Date</div> <div>2024-05-24 (09:00 - 09:15)</div> |