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	:	2024-06-08

FULL NAME:: SHAAD CONTACT NO.:971503380880 AGE :22

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€¦â€¦.yoland.com)

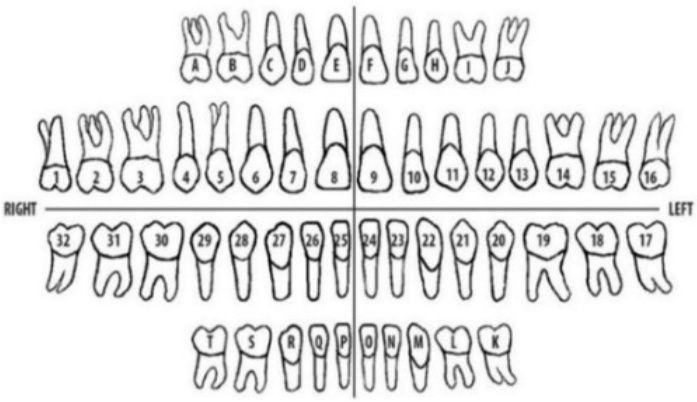
Reason for Referral:
☑Consultation ☐radion

☐Comprehensivecare
☐ 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 Restorative
☐ Orthodontic care

☐ Extractions
☐ Sedation
☐ Special needs (specify type):

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 SHAAD SAIF ALSHAB Date 2024-06-08 (09:45 - 10:00)	Doctor Name Dr Nadir El Tayeb - Dental (DHA-T-00171042) Date 2024-06-08 (09:45 - 10:00)