

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		2024-06-06

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)

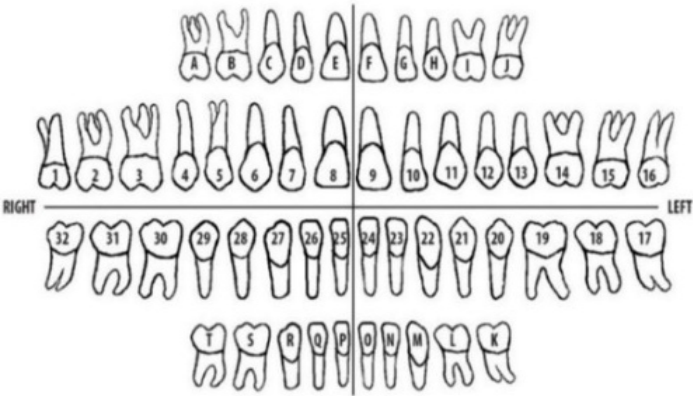
Interpreter needed:
☐YES ☐No

☐X-rays emailed ☐X-rays with patient ☐Need X-rays (please send X-rays to info@yoland.com)

Reason for Referral:
☐Consultation ☒radion

- ☐Comprehensivecare
- ☐ Endo: RCT only
- ☒ Extractions
- ☐ Crowns
- ☐Endo:RCT,Permanent
- ☒ Sedation
- ☐ Bridges
- Restoration/Crown
- ☐ Special needs (specify type):
- ☐Denture:Complete
- ☐Periodontal Care
- ☐ Denture: Partial
- ☐ Implants: Surgical only
- ☐ Denture:Overdenture
- ☐Implants:Surgical Restorative
- ☐ Complex medical needs
- ☐ Orthodontic care

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
	<div></div>

<div>Patient Name</div> <div>SHAAD SAIF ALSHAB</div> <div>Date</div> <div>2024-06-06 (19:45 - 20:45)</div>	<div>Doctor Name</div> <div>Dr Nadir El Tayeb - Dental (DHA-T-00171042)</div> <div>Date</div> <div>2024-06-06 (19:45 - 20:45)</div>
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