

Dental External Referral Form								
Patient Name		: AAAAAA			Emirates ID		: 999-9999-999999-9	
File No		: 3127	DOB		: 2018-06-07	Nationality		: Emirati
Gender		:	Doctor's Name		: Dr Nadir El Tayeb	Date		: 2024-06-01

FULL NAME::AAAAAA CONTACT NO.:0 AGE :5

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 ahmed.yoland.com)

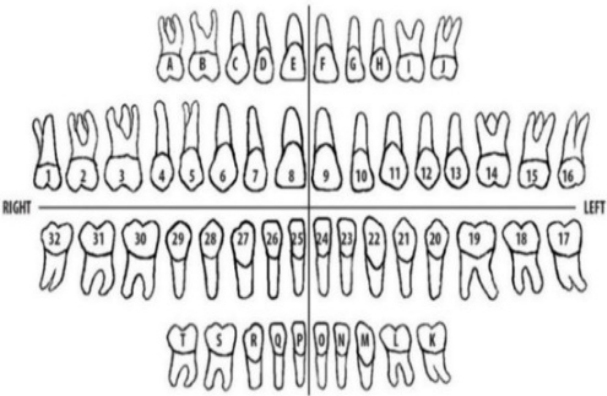
Reason for Referral: ☒Consultation ☐radion

☐ Comprehensive care ☐ Crowns ☐ Bridges ☐ Denture: Complete ☐ Denture: Partial ☐ Denture: Complex Overdenture medical needs

☒ Endo: RCT only ☒ Endo: Permanent Restoration/Crown RCT, ☒ Periodontal Care ☒ Implants: Surgical only ☐ Implants: Surgical and Restorative ☐ Orthodontic care


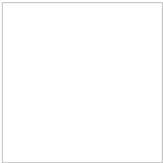
☐ Extractions ☐ Sedation ☐ Special needs (specify type):

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

	
<div>Patient Name AAAAAA</div> <div>Date 2024-06-01 (09:45 - 10:00)</div>	<div>Doctor Name Dr Nadir El Tayeb - Dental (DHA-T-00171042)</div> <div>Date 2024-06-01 (09:45 - 10:00)</div>