

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 khloud sharfi  Date 2024-06-03 (13:15 - 13:45 )	Doctor Name Dr Nadir El Tayeb - Dental (DHA-T-00171042)  Date 2024-06-03 (13:15 - 13:45 )

