

Dental External Referral Form								
Patient Name	:	Afra Khalid Al Muhairi(Mom)		Emirates ID	:	999-9999-999999-9		
File No	:	6185	DOB	:	2006-10-14	Nationality	:	Emirati
Gender	:	Female	Doctor's Name	:	Dr Nadir El Tayeb	Date	:	2024-06-06

FULL NAME::Afra Khalid Al Muhairi(Mom) CONTACT NO.:504661100 AGE :17

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)

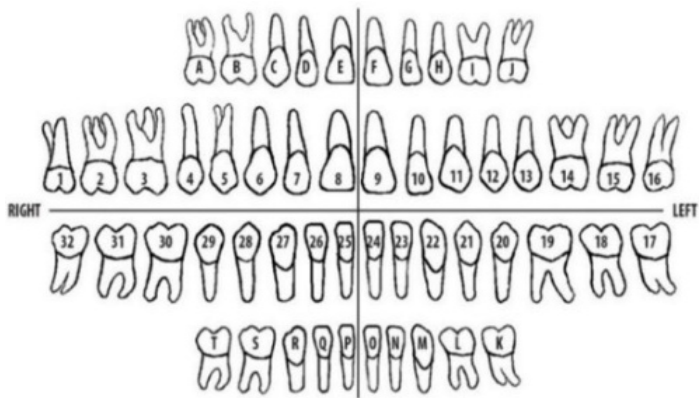
Reason for Referral:

- ☒Consultation ☐radion

- |                                                |                                                                          |                                                        |
|------------------------------------------------|--------------------------------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> Comprehensivecare     | <input checked="" type="checkbox"/> Endo: RCT only                       | <input type="checkbox"/> Extractions                   |
| <input type="checkbox"/> Crowns                | <input checked="" type="checkbox"/> Endo:RCT,Permanent Restoration/Crown | <input type="checkbox"/> Sedation                      |
| <input type="checkbox"/> Bridges               | <input checked="" 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 type="checkbox"/> Implants:Surgical Restorative                   |                                                        |
| <input type="checkbox"/> Denture:Overdenture   | <input type="checkbox"/> Orthodontic care                                |                                                        |
| <input type="checkbox"/> Complex medical needs |                                                                          |                                                        |

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 Afra Khalid Al Muhairi(Mom)  Date 2024-06-06 (09:15 - 09:30 )</div>	<div>Doctor Name Dr Nadir El Tayeb - Dental (DHA-T-00171042)  Date 2024-06-06 (09:15 - 09:30 )</div>

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