

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		2024-05-29

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

Referring Healthcare professional : Dr Nadir El Tayeb

PROPHYLACTIC

☐ Emergent (send patient to ED)

☐ Urgent (24-72 hours)

☐ Routine (next available)

Interpreter needed::
Email Option:

☐ YES

☐ No

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

EXAMINATION:

☐ Comprehensive care

☐ Endo:RCT only

☐ Extractions

☐ Crowns

☐ Endo:RCT,Permanent Restoration/Crown

☐ Sedation

☐ Bridges

☐ Periodontal Care

☐ Special needs(specify type):

☐ Denture: Complete

☐ Implants: Surgical only

☐ Denture: Partial

☐ Implants:Surgical and Restorative

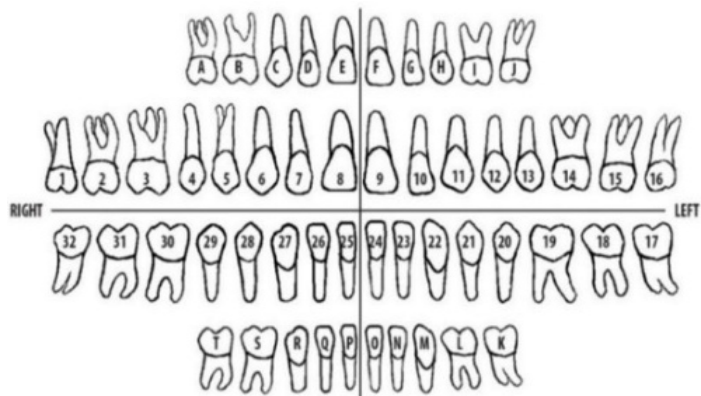
☐ Denture: Overdenture

☐ Orthodontic care

☐ Complex medical needs:

☐ Please provide written report via Email

Reason for Referral: ☐ Consultation ☐ radion Patient is ☐ verbal ☐ non-verbal



Evaluated by :Dr Nadir El Tayeb

Sign here, only if all of your questions have been answered to your satisfaction	
PATIENT	DOCTOR
	<div></div>
Patient Name SHAAD SAIF ALSHAB Date 2024-05-29 (08:00 - 08:15)	Doctor Name Dr Nadir El Tayeb - Dental (DHA-T-00171042) Date 2024-05-29 (08:00 - 08:15)