

Dental External Referral Form								
Patient Name	:	Abeer Al Masri Al Shaarani		Emirates ID	:	999-9999-999999-9		
File No	:	5132	DOB	:	1973-05-09	Nationality	:	Emirati
Gender	:	Female	Doctor's Name	:	Dr Nadir El Tayeb	Date	:	2024-06-06

FULL NAME::Abeer Al Masri Al ShaaraniCONTACT NO.:508068807AGE :51

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)

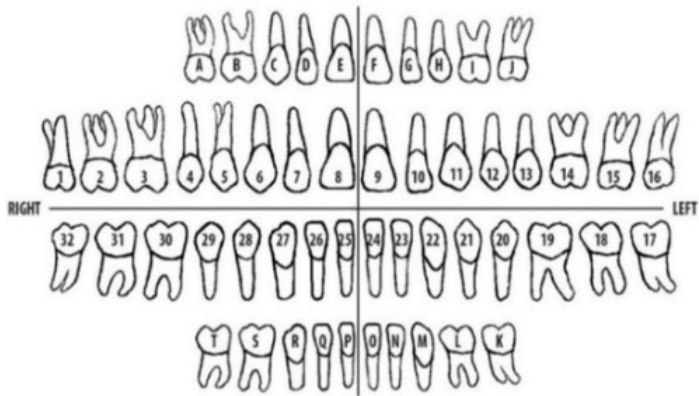
Reason for Referral:

- ☒Consultation☐radion

- | | | |
|--|--|--|
| <input type="checkbox"/> Comprehensivecare | <input 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 type="checkbox"/> Periodontal Care | <input type="checkbox"/> Special needs (specify type): |
| <input type="checkbox"/> Denture:Complete | <input checked="" type="checkbox"/> Implants: Surgical only | |
| <input type="checkbox"/> Denture: Partial | <input checked="" 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</div> <div>Abeer Al Masri Al Shaarani</div> <div>Date</div> <div>2024-06-06 (10:45 - 11:00)</div>	<div>Doctor Name</div> <div>Dr Nadir El Tayeb - Dental (DHA-T-00171042)</div> <div>Date</div> <div>2024-06-06 (10:45 - 11:00)</div>
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