

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)

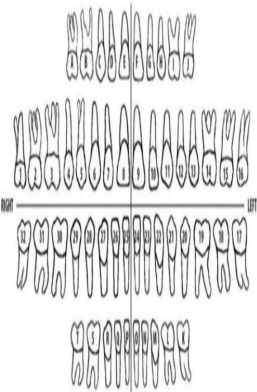
Interpreter needed: ☐YES ☐No

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

Reason for Referral: ☐ Consultation ☐ Consultation radion

☐ Comprehensive only ☐ Endo: RCT ☐ Endo: Extractions
care ☐ Crowns RCT, permanent ☐
☐ Bridges ☐ restoration/crown Sedation ☐
Denture: ☐ Periodontal Special
Complete ☐ care ☐ Implants: needs
Denture: Surgical only ☒ (specify
Partial ☐ Implants: type):
Denture: Surgical and
Overdenture ☐ restorative ☒
Complex Orthodontic care
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 khloud sharfi</div> <div>Date 2024-06-03 (11:45 - 12:00)</div>	<div>Doctor Name Dr Nadir El Tayeb - Dental (DHA-T-00171042)</div> <div>Date 2024-06-03 (11:45 - 12:00)</div>