

Dental Internal Referral Form								
Patient Name	:	AAAAAA			Emirates ID	:	999-9999-999999-9	
File No	:	3127	DOB	:	2018-06-07	Nationality	:	Emirati
Gender	:		Doctor's Name	:	Dr Nadir El Tayeb	Date	:	2024-06-01

FULL NAME::AAAAAA CONTACT NO.:0 AGE :5

Referring Healthcare professional : Dr Nadir El Tayeb

☒Emergent (send patient to ED) ☒Urgent (24-72 hours) ☐Routine (next available)


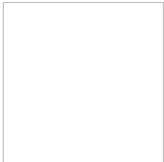
☐X-rays emailed ☐X-rays with patient ☐Need X-rays (please send X-rays to info@yoland.com)

Reason for Referral: ☐Consultation ☐radion

EXAMINATION:

<input checked="" type="checkbox"/> Comprehensive care	<input checked="" type="checkbox"/> Endo:RCT only	<input checked="" type="checkbox"/> Extractions
<input type="checkbox"/> Crowns	<input 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):
Patents:	<input type="checkbox"/> verbal	<input checked="" type="checkbox"/> Non verbal
<input checked="" type="checkbox"/> Denture: Complete	<input type="checkbox"/> Implants: Surgical only	<input type="checkbox"/> Denture: Partial
<input type="checkbox"/> Implants:Surgical and Restorative	<input type="checkbox"/> Denture: Overdenture	<input type="checkbox"/> Orthodontic care
<input type="checkbox"/> Complex medical needs:		

Evaluated by :Dr Nadir El Tayeb

Sign here, only if all of your questions have been answered to your satisfaction	
PATIENT	DOCTOR
	

<div>Patient Name</div> <div>AAAAAA</div> <div>Date</div> <div>2024-06-01 (09:45 - 10:00)</div>	<div>Doctor Name</div> <div>Dr Nadir El Tayeb - Dental (DHA-T-00171042)</div> <div>Date</div> <div>2024-06-01 (09:45 - 10:00)</div>
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