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	CONT	ACT NO.:50 650 9950	AGE :124
Referring Healthcare professional	: Dr Na	dir El Tayeb	
<b>☑</b> Emergent (send patient to ED)		<b>☑</b> Urgent (24-72 hours)	☐Routine (next available)
Interpreter needed:	□YES	□No	
▼X-rays emailed ▼X-rays with p	oatient	□Need X-rays (please send	l X-rays to …….yoland.com
Reason for Referral:	□ Consulta	□ ation radion	
☐ Comprehensive care			
✓ Crowns			
□ Bridges			
□ Denture: Complete			
□ Denture: Partial			
□ Denture: Overdenture			

endo: rct onl	у	
endo: ro	t, perm	anent
restoration/crow	/n	
□ periodontal c	are	
☑ implants: sur	rgical only	
	surgical	and
restorative		
orthodontic c	are	
man and an am		
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## ☐ Please provide written report via Email

Sign here, only if all of your questions have been answered to your satisfaction				
PATIENT	DOCTOR			
Patient Name khloud sharfi Date 2024-06-03 (18:00 - 19:45 )	Doctor Name Dr Nadir El Tayeb - Dental (DHA-T- 00171042)  Date 2024-06-03 (18:00 - 19:45)			