

Dental External Referral Form								
Patient Name	:	Adhari Mohammed AIShehhi(dr.n)		Emirates ID	:	999-9999-999999-9		
File No	:	5909	DOB	:	1988-02-13	Nationality	:	Emirati
Gender	:	Female	Doctor's Name	:	Dr Nadir El Tayeb	Date	:	2024-06-06

FULL NAME::Adhari Mohammed AIShehhi(dr.n) CONTACT NO.:555054005 AGE :36

Referring Healthcare professional : Dr Nadir El Tayeb

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

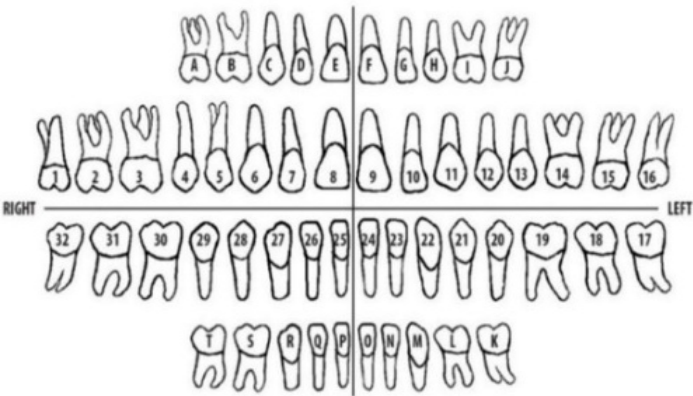
Interpreter needed:
☒YES ☐No

☐X-rays emailed ☐X-rays with patient ☒Need X-rays (please send X-rays to â€|â€|.yoland.com)

Reason for Referral:
☒Consultation ☐radion

- ☐Comprehensivecare
☐Crowns
☐Bridges
☒Denture:Complete
☐Denture: Partial
☐Denture:Overdenture
☐Complex medical needs
- ☒Endo: RCT only
☒Endo:RCT,Permanent Restoration/Crown
☐Periodontal Care
☐Implants: Surgical only
☐Implants:Surgical Restorative
☐Orthodontic care
- ☐Extractions
☐Sedation
☐Special needs (specify type):

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 Adhari Mohammed AlShehhi(dr.n) Date 2024-06-06 (09:00 - 09:15)</div>	<div>Doctor Name Dr Nadir El Tayeb - Dental (DHA-T-00171042) Date 2024-06-06 (09:00 - 09:15)</div>

□