



Referral form

Bath Oral Surgery Clinic

Please use the labels provided when returning this form.

Referrals can also be made online at: www.bathoralsurgeryclinic.co.uk

Practitioner's name

Address _____

Postcode _____

Telephone _____

Email _____

Practice stamp

Patient's name

Address _____

Postcode _____

Have we seen this patient before?

Date of Birth _____

Daytime telephone _____

Evening telephone _____

Email _____

yes no

Brief description of request

Is the treatment urgent?

yes no

Preferred treatment location

Salford Trowbridge

Has the patient experienced these signs or symptoms:

pain swelling pericoronitis bad taste recurrent infection

Other symptoms *(please specify)*

Has the tooth been root treated? *(Apicectomy referrals)*

yes no

Relevant medical history *(including allergies and current medication)*

Is treatment to be carried out with intravenous sedation?

yes no

Has patient any previous sedation experience?

yes no

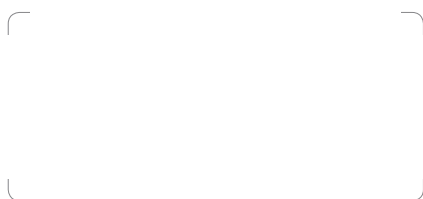
Has the patient been informed of the likely costs?

yes no

Radiographs enclosed required

details

Other comments



You can peel this sticker off for your own records

Thank you for your referral