

## PATIENT REFERRAL FORM (1/2)

If you prefer to discuss a case prior to referral please contact a Patient Advisor who will direct your call accordingly.

### Referral type (please tick)

- Minor surgical procedures (please state) .....  Botox®/Restylane  
 Laser hair removal  Medical Microdermabrasion  Chemical peel

### Referring Practitioner details

Title:	Name:	
Business address:		
Tel No:	Fax No:	Email:
Preferred communication method: <input type="checkbox"/> Letter <input type="checkbox"/> Telephone <input type="checkbox"/> Fax <input type="checkbox"/> Email		

### Patient details

Title:	Name:	DOB:
Home address:		
Tel No:	Fax No:	Email:
Preferred communication method: <input type="checkbox"/> Letter <input type="checkbox"/> Telephone <input type="checkbox"/> Fax <input type="checkbox"/> Email		

### Medical history (as relevant, tick box if yes and provide details)

The patient is currently undergoing treatment from their GP and/or specialist:

The patient is currently taking medication/s and/or has an underlying medical condition:

### Special history (tick box if yes)

The patient has a relevant physical disability  The patient has additional special needs



Reason for referral
History of reason for referral:
How long has the problem been apparent?
Which treatment modalities have been tried?
Please give details of any relevant treatment to date:

Any other information (tick box if yes)	
<input type="checkbox"/> Enclosures	<input type="checkbox"/> Enclosures to be returned

NB Your patient will be referred back to you at the end of any treatment. Thank you for your kind referral.

Referring Practitioner Signature: ..... Date: .....

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