Referral Form

Patients will only receive the treatment they have been referred for and will be returned to the referring practitioner on completion of treatment

GHYLLMOUNT Dental Practice
4 Hobson Court, Penrith, Cumbria, CA11 9GQ
01768 862291 reception@ghyllmountdental.co.uk

Referral for: *(please tick)*

- ○ All implant treatment
- ○ Implant surgery only
- ○ Invisalign
- ○ Private orthodontics
- ○ Endodontics
- ○ Facial rejuvenation

Treatment Requested: *(please tick)*

- ○ Consultation only
- ○ Consultation and treatment

Patients Name Mr/Mrs/Ms/Miss/Dr/Other (Specify)

Date of Birth

Address

Telephone Number

Postcode

Email Address

Reason for referral

Relevant medical history

Name and address of referring dentist

Telephone number

Postcode

Email address

Signature

Date of referral

Please send any relevant radiographs by post or by email and they will be returned to you on completion of treatment