RED LODGE
DENTAL SURGERY

Implant, Orthodontic and Sedation Referral Centre

Referral Form

Date of Referral			
Patient Name			
Date of Birth		**Gender**	
Address			
Mobile No		**Home No**	

Treatment Required/Complaint

Implants ◯ **Periodontics** ◯ **Oral Surgery** ◯ **Prosthodontics** ◯ **Orthodontics** ◯

Please fill out the details of the treatment required & Relevant Medical History

Attachments	**Medical History** ◯ **Radiographs** ◯ **Other** ◯
Sedation requested	**Yes** ◯ **No** ◯

Referring Dentist	
Practice Name	
Address	
Telephone No	
Email	

Please send your completed form to the below address or email to info@redlodgedentalsugery.co.uk