# Periodontal Clinic Referral

enhance
periodontal clinic

GDP name: _____

Clinic name: _____ Postcode: _____

Contact tel: _____

## Patient Details:

Date of birth: | D | D | M | M | Y | Y | Y | Y |

Title: _____ Name: _____

Address: _____

_____

_____ Postcode: _____

Tel home: _____ Tel mobile: _____

Parent / Guardian name: _____

## Initial Diagnosis / Reason for Referral (please tick)

☐ Hygienist assessment*

☐ Consultant periodontist assessment*

## BPE

| | | |
|---|---|---|
| | | |

Further comments: _____

_____

_____

Relevant medical history: _____

_____

_____

Relevant past dental history: _____

_____

_____

Would you like to discuss this referral informally on the phone? _____

Signed: _____ Date: _____

*Please inform the patient of relevant charges

**Please send completed form to: Enhance, 68 St Mary's Street, Ely, Cambs, CB7 4HH**

Email: referrals@enhance.myzen.co.uk