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**PERIODONTAL REFERRALS**

**Mrs ENNATA ADELEYE** DDS, MSc (Perio), FDS RCS (Eng)

Practice Limited to Periodontology

**REFERRING PRACTITIONER’S DETAILS**

**Name:** …………………………………………………………………………………………………….……… **Date:** ………………..…………..

**Practice Address:** ………………………………………………………………………………………………………………………...…………..

…………………………………………………………………………………………………………………………………………………………….

…………………………………………………………....................**Practice Contact Number:** …………………………………………………

**PATIENT’S DETAILS**

**Patient’s Name:** ……………………………………………………………………………………………….. **D.O.B:** ……………………….……

**Patient’s Address:** ……………………………………………………………………………………………………………………………………

……………………………………………………………………………………………………………………………………….……………………

**Patient’s Contact Numbers: Home:** …………………………….. **Mobile:** …………………….……….**Work:** ………………………………

**REFERRAL FOR:**

|  |
| --- |
|  |

Periodontal Assessment and Treatment

|  |
| --- |
|  |

Periodontal Assessment and Treatment Plan Only

|  |
| --- |
|  |

Surgical Crown Lengthening

Teeth/tooth ………………………………………………

Medical History: ……………………………………………………………………………………………………………………………..

……………………..………………………………………………………………………… Smoker **Yes** **No**

Radiographs\* enclosed (up to 1 year old): **Yes No** E-mailed **Yes** **No**

**Patient’s consent obtained for referral? Yes No**

**More referral forms needed Yes No**

\*Radiographs and the form can be e-mailed to: [forgehouse.dentalpractice@nhs.net](mailto:forgehouse.dentalpractice@nhs.net) or info@forgehousedental.co.uk