CAUSEWAY &
BLACKHORSE WAY
DENTAL PRACTICE

# Minor OralSurgery Referral Form

**Patient Information:**

Title:

Forename:

Surname:

DOB:

**Address:**

**Telephone**:

**Mobile:**

**Email**:

**Medical history:**

**Medications:**

**Allergies:**

**Smoker:** YES / NO / PAST
**No Per Day :** _____

☐ **Extraction (apicectomy)** ☐ **Consultation** ☐ **Soft tissue**

**Diagnosis:**

**Reason for referral/reason for treatment:**

☐ **Recent x-ray included***

*Not required for soft tissue. Mandatory for dentoalveolar surgery and consultation.

**Referring dentist:**
**Address:**

**Date of Referral:**
**Telephone:**

***Office use only:***

X-ray uploaded to CW database? ☐Yes ☐N/A

Actions Needed: _____

Dentist Referral Allocated to: _____

Signature: _____ Date: _____

Once you have completed this form, please submit it by post to our practice manager.
All information provided will be treated with the strictest confidence. Thank you.

The Causeway Dental Practice, 8 Causeway, Horsham, West Sussex, RH12 1HE