



## Hygienist Referral Form

### **Patient Information:**

Mr  Mrs  Miss  Ms

Surname: \_\_\_\_\_ Forename: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Postcode: \_\_\_\_\_

Tel (Primary): \_\_\_\_\_ Tel (other): \_\_\_\_\_ E-Mail: \_\_\_\_\_

### **Relevant Medical History (including medications):**

\_\_\_\_\_  
\_\_\_\_\_

### **Reason for Referral:**

Chronic Periodontitis  Chronic Gingivitis  Maintenance

Generalised  Localised

Other: \_\_\_\_\_

Special Instructions / requests: \_\_\_\_\_

Treatment planned or undertaken: \_\_\_\_\_

Radiographs Included?  Yes  No BPE: 

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

Pocket Chart Included?  Yes  No 

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

### **Referring Dentist:**

Name: \_\_\_\_\_ Practice Address: \_\_\_\_\_

Postcode: \_\_\_\_\_

Tel: \_\_\_\_\_ E-Mail: \_\_\_\_\_

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.