The Causeway & Blackhorse Way Dental Practices
Sussex Health Care Group

Minor Oral Surgery Referral Form

Patient Information:

Title:_____

Surname: Forename: DOB:

Address:

Postcode:

Tel (Home) Tel (Mobile)

E-mail:

Patient Information:

Tooth Requiring Extraction: _____

☐ Extraction of the above tooth ☐Second opinion about the above tooth

Indication (please specify in as much detail as possible):_____

_____

Is the tooth symptomatic? ☐Yes ☐No

Has the tooth been extirpated? ☐Yes ☐No

Is a radiograph attached? ☐Yes ☐No

Does the patient need a consultation first? ☐Yes ☐No

Relevant Medical History (including medications): _____

_____

Referring Dentist:

Name: Practice:

Signature: _____ Date of Referral:

Office use only:

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

Actions Needed: _____

_____

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