# Dental Clinic Referral

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: ______________________________

**Reason for Referral** (please tick)

☐ Dental Clinic assessment
☐ Implants*
☐ Orthodontics*
☐ Endodontics

Short summary of case: ______________________________

______________________________

______________________________

Relevant medical history: ______________________________

______________________________

______________________________

Relevant past dental history: ______________________________

______________________________

______________________________

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

Signed: ______________________ Date: ______________

*Please inform patients that the initial consultation is free of charge but fees may be incurred if specialized radiographs are required (CBCT scan or lateral ceph scan).

**Please send completed form to: Enhance, 68 St Mary's Street, Ely, Cambs, CB7 4HH**
Email: referrals@enhance.myzen.co.uk