

Referral Form



GHYLLMOUNT
Dental Practice

4 Hobson Court, Penrith, Cumbria, CA11 9GQ
01768 862291 reception@ghyllmountdental.co.uk

Patients will only receive the treatment they have been referred for and will be returned to the referring practitioner on completion of treatment

Referral for: *(please tick)*

- | | | |
|---|--|---|
| <input type="radio"/> All implant treatment | <input type="radio"/> Implant surgery only | <input type="radio"/> Invisalign |
| <input type="radio"/> Private orthodontics | <input type="radio"/> Endodontics | <input type="radio"/> Facial rejuvenation |

Treatment Requested: *(please tick)*

- | | |
|---|--|
| <input type="radio"/> Consultation only | <input type="radio"/> Consultation and treatment |
|---|--|

Patients Name Mr/Mrs/Ms/Miss/Dr/Other (Specify)

Date of Birth

Address

Telephone Number

Postcode

Email Address

Reason for referral

Relevant medical history

Name and address of referring dentist

Telephone number

Postcode

Email address

Signature

Date of referral

Please send any relevant radiographs by post or by email and they will be returned to you on completion of treatment