LINK HOUSE

Patient Referral Form

Referring Dentist / Hygienist / Clinician:

Name

Name of Practice

Practice Address

Address Line 2

Postcode

Telephone Number

Email Address

Preferred method of receiving report

☐ Email ☐ Post

Treatment Type (please tick):

- ☐ Periodontics
- ☐ Periodontal Surgery / Mucogingival Surgery
- ☐ Endodontics
- ☐ Endodontic Surgery
- ☐ Prosthodontics / Restorative
- ☐ Smile Design / Cosmetic Treatment
- ☐ Dental Implants (full care)
- ☐ Dental Implants (grafting / placement only)
- ☐ Oral Surgery
- ☐ Crown Lengthening
- ☐ Multidisciplinary Treatment

Patient Details:

Title **First Name** **Surname**

D.O.B (dd/mm/yyyy) **Address** **Postcode**

Preferred Contact Number **Email Address**

Medical History of Note

Clinical Details

Please tick as appropriate

- ☐ The referral is urgent
- ☐ Discuss the option of sedation
- ☐ Provide an opinion only
- ☐ I would like the specialist to contact me to discuss the case

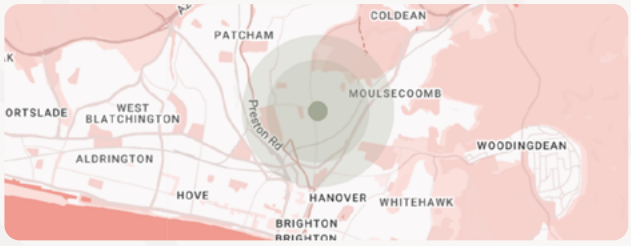
X-rays & Photos

Please help us reduce x-ray exposure by sharing any available images.

Email them to care@linkhousecentre.co.uk (include the patient name) or use our online form at www.linkhousecentre.co.uk.co.uk

☐ I have **no** x-rays or pictures to send

☐ **I confirm I have the patient's consent to share their details and clinical data with Link House**



reception@linkhousecentre.co.uk
01273 044 990
www.linkhousecentre.co.uk

Link House | Link Place | Upper Hollingdean Road | Brighton | BN1 7DU

LINK HOUSE

We aim to contact patients within 24 hours of receiving the referral.

For multidisciplinary referrals, please provide as much detail as possible to ensure we direct the patient to the appropriate clinician.

Once treatment is successfully completed, the patient will be returned to you for continued care.