HYGIENIST REFERRAL

Grosvenor House
Orthodontic Practice

PRACTICE INFORMATION

Name:

Address:

Telephone Number:

E-mail:

REFERRING DENTIST

Name: Address: Postcode:

Tel: Fax: E-mail:

PATIENT DETAILS

Name: Address: Postcode:

DOB: Mobile: Tel no. Home: Work:

MEDICAL HISTORY

REASON FOR REFERRAL / CURRENT PERIO STATUS

RADIOGRAPHS - Please Tick

Please send recent radiographs (these will be returned) / or ☐

Please take appropriate xrays (copies will be sent to you). ☐

TREATMENT REQUIRED

Please can you see this patient for the following care, advice and treatment to include: ☐

- Treatment Discussion
- BPE/ Full Periodontal Charting
- Home care guidance
- Arrange further appointments with the patients as necessary

ADDITIONAL PRESCRIPTION REQUIREMENTS

LA is a 'prescription only medicine' and the referring dentist must authorise LA for the hygienist to use, this also applies to fluoride varnish and high fluoride toothpaste.

Please complete the following;

LA type, dosage & frequency: ☐

Fluoride Varnish 2.26% NaF: ☐ Dosage: _____

Toothpaste: Sodium Fluoride toothpaste 2800ppm (0.619% DPF) ☐ 5000ppm (1.1% DPF) ☐ Frequency _____

SUPPORTIVE PERIODONTAL THERAPY

1 Year ☐ 2 Years ☐ 3 Years ☐ (Maintenance can be valid up to 3 years)

Please tick when you wish to see the patient following inital therapy: 3Months ☐ 6Months ☐ 1 Year ☐

Feel free to contact me at the practice to discuss further if necessary.

Please sign below to confirm referral, thank you

Signature of Dentist

Date