# HYGIENIST REFERRAL

THE PARADE
SPECIALIST DENTAL CENTRE

## 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**