BEAULIEU
Dental Practice

Date of Referral:

PERSONAL INFORMATION

Full Name : Date of Birth :

Address :

Postcode: Phone Number:

Medical History :

GP Name, Contact Number and Address :

REFERRING DENTIST DETAILS

Dentist Name : Contact Number :

Practice Address :

Email Address :

TREATMENT REQUIRED (PLEASE TICK BOX REQUIRED)

- ☐ Surgical removal/ buried root extractions
- ☐ Surgical removal of impacted wisdom teeth/ buried teeth
- ☐ Coronectomy of impacted teeth where there is a high risk of nerve injury
- ☐ Placement of oral implants and prosthesis
- ☐ Bone grafting
- ☐ Apicetomy
- ☐ Closure/ repair of oro- antral fistulae
- ☐ Incisional and excisional biopsies of lesions in the mouth including the lips, tongue and palate
- ☐ Labial and lingual frenectomy
- ☐ Enucleation or marsupilization of cysts of jaw
- ☐ Surgical orthodontics/ exposure of impacted teeth and placement of bracket and chain and removal of impacted supernumerary teeth
- ☐ Other oral surgery procedures

Teeth/ Area to be treated (further reason for referral):

Signature of Referring Dentist:

Please email all referrals to beaulieudental@btinternet.com