

HYGIENIST/THERAPIST REFERRAL FORM

TO

FROM

<p style="text-align: center;">Dental Specialists MK</p> <p>259 Queensway Bletchley Milton Keynes MK2 2EH</p> <p style="text-align: right;">Tel/Fax:01908 630169</p>	
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Referring Dentist's practice Stamp

PATIENT'S DETAILS

*FULL NAME & TITLE Dr/Mr/Mrs/Miss/Ms

*DATE OF BIRTHGENDER M/F

*ADDRESS

.....

.....POSTCODE

*TEL. NO. HOME WORK

Dear Tina,

Please can you see and treat the above patient for the following:

OHI Tell-show-do technique for behavioural modification with regards to:

- ETB
- Manual t/b
- Floss
- Superfloss
- Single Tufted Brush
- Interproximal Brushes
- Other Aid

DISCLOSING

- ScalinSealants
- Root Surface Debridement
- Antibiotic Therapy
- Use of Local Anaesthetic
- Polishing
- Air Machine Polishing
- Fissure please specify teeth:

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Areas of Special Attention:
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PRIVATE PAEDIATRIC TREATMENT

- OH1
- Scale and Polish
- Restoration
- Extractions
- Fissure Sealants

Please note teeth for treatment

Other notes:

Many Thanks,

(Signature of Dentist)

MRS T OCAL EDH, EDT,RCS (Eng)
Hygienist/Therapist