



DENTAL ROOMS  
WIMBLEDON VILLAGE

SPECIALIST REFERRAL FORM

**Patient detail:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

D.O.B. \_\_\_\_\_

Tel: (W) \_\_\_\_\_  
(H) \_\_\_\_\_  
(M) \_\_\_\_\_

E-mail: \_\_\_\_\_

**Referring dentist details:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Tel: (W) \_\_\_\_\_  
(H) \_\_\_\_\_  
(M) \_\_\_\_\_

E-mail: \_\_\_\_\_

**Dental Specialty:** (Please Circle)

Endodontics	Periodontics	Prosthodontics
Orthodontics	Surgical Dentistry	Radiography
Mentoring	Implant Surgery	Implant & Restoration

**Reason for Referral:**

**Relevant Medical History:**

**Priority:** Urgent / Non-Urgent

**Radiographs enclosed:** Y / N

**Signature of Referring Dentist:**

**Date:**