**Oral Surgery Patient Referral Form**

Please send completed referral form with radiographs if appropriate to this secure email address: **chelwooddentalleeds.co.uk**

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| --- |
| Patient Details |
| Full name: |  |
| D.O.B: |  | Contact number: |  |

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| --- |
| Reason for Referral |

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| --- |
| Please include any relevant medical history and medications |
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| Referring Practitioner Details |
| Full name: |  |
| Practice name: |  |
| Practice address: |  |

Thank you for your referral

On receipt of referral, the booking team will aim to contact the patient directly within 24 hours