SPECIALIST
ENDODONTIC CENTRE

20 Goldsmith Avenue – Portsmouth - PO4 8QT - P 023 9275 4333 – E info@specialistendocentre.co.uk
47 The Avenue – Southampton – SO17 1XP - P 023 8144 7800 – E chelsea@specialistendocentre.co.uk

REFERRAL FORM

REFER PATIENT TO ☐ **Portsmouth Practice** ☐ **Southampton Practice**

REFERRING DENTIST

Practice Name: _____

Dentist Name: _____

Address: _____

Post Code: _____Tel: _____

E-mail: _____

PATIENT DETAILS

Name: _____

Date of Birth: _____

Address: _____

Phone: (Landline) _____

Phone: (Mobile) _____

Email: _____

REASON FOR REFERRAL

- ☐ Consultation
- ☐ RCT / Re RCT
- ☐ Microsurgery
- ☐ Post & Core Build-up
- ☐ CBCT
- ☐ CBCT with Report

OTHER INFORMATION

- ☐ X-Ray Attached
- ☐ Please send some Referral Forms
- ☐ Please send my portal login
- ☐ Please call me

Relevant Medical History: _____

REASON FOR REFERRAL

Tooth / Area to Evaluate: _____

Further Information: _____

_____

_____

_____

_____

Date: _____