



66 High Street, Broadstairs
CT10 1JT

1A Stanhope Road, Deal
CT14 6AB

Unit 31 Roper Close, Canterbury
CT2 7EP

Patient Referral Form

Date:.....

Name of referring Dentist:.....

Patient Contact Details

Title:..... **Surname:**.....

First Name:..... **Date of Birth:**.....

Address:..... **Contact number:**.....

..... **Email Address:**.....

..... **Allergies:**.....

Postcode:.....

Serious medical conditions: Example COPD/Angina/ High Blood Pressure/Asthma/Epilepsy/Diabetes

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Reason for referral/treatment plan

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Dentist Signature:.....

Dentist GDC no:

The Denture Clinic will contact the above named patient and arrange for the above treatment plan to be carried out with one of our Clinical Dental Technicians. Where the treatment plan cannot be completed, the CDT will contact the dentist to discuss alternative treatment.