Referral Form

Highfield Dental Clinic · 2 Highfield Road, Birmingham B15 3ED

Email the form to **reception@highfielddental.co.uk**

Referrer

Referrer name

Practice name and postcode

Practice phone or email

Referral date (DD/MM/YYYY)

Patient

Full name

Date of birth (DD/MM/YYYY)

Phone number

Referral details

Assessment or treatment requested

Tooth or site, if relevant

Reason for referral and relevant medical history

X-rays or other records, if included

Has the patient agreed to the referral and sharing relevant information? (Yes or No)