Highfield Dental Clinic

Patient Referral Form

Please fill in ALL fields and return this form to reception@sagroups.co.uk

Referral date:

Referring dentist:

Surgery address:

Surgery telephone number:

Surgery email address:

Patient name:

Date of birth:

Address:

Contact number:

Email address:

Please indicate reason for referral below:

Endodontics

- ☐ Consultation only
- ☐ Primary root canal
- ☐ Re-root canal
- ☐ Apicectomy
- ☐ Endodontic surgery

Orthodontics

- ☐ Consultation
- ☐ Treatment and advice
- ☐ Second opinion

Implants and Oral Surgery

- ☐ Implant consultation and advice
- ☐ CBCT assessment and advice
- ☐ Surgical removal of tooth or teeth (please specify tooth notation)

Please add any additional information necessary for referral here:

Dentist signature: