CBC Dental Studio

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Referral form

We welcome referrals from other general dental practitioners.

We will complete your patient's treatment, providing you with comprehensive updates and a final report, and return them to you for ongoing care and maintenance. Please complete the form below and we will contact you in due course.

Type of referral: ☐ **Root Canal Therapy** ☐ **Gum Disease Treatment** ☐ **Teeth Straightening**

☐ **Wisdom Tooth/Teeth Extraction** ☐ **Dental Implants** ☐ **Other (please specify) ……**

Reason for Referral: ☐ **Consultation** ☐ **Treatment** ☐ **Second opinion only** ☐ **All of the above**

PATIENT INFORMATION:	
Name:	
Address:	
Phone number:	**Patient DOB:**
Email:	

PREFERRED TREATMENT NOTES:

CLINICAL INDICATIONS:

MEDICAL HISTORY:

Referring Practice Name:		**Clinician Name:**
Clinician Email:		**Telephone:**
Please enclose any X-rays or OPG images		