

GDP REFERRAL FORM

Date of referral			Patient's Da of Birth	te		Gender (please tick)	Male	Female	
Referral Type (ple	ease tick)	Perio		Endo		Extraction	ı		
Patient's Surname				Patient's Forename					
	Contact	phone num	ıber:						
Daytime Phone				Mobile Pho	one				
Does your patient need to communicate in a language or mode other than English? If yes please specify.									
G	DP Stamp ,	<u>/ Address</u>		Academ accept p stone/13 Please ti I confirm reason fo undertal	y referral o atients wh 35 KG). ck to confi ck to confi n I have inf or referral ken by stu	referral meet criteria (pleas no weigh in et irm formed the p and that trea dents and it i	e note v xcess of atient of atment v	the vill be	
Telephone numbe	er:			by specia Please ti Print Na (Dentist) Signed (Dentist)	ck to confi me	irm			

Radiographs are needed for Periodontics, extraction and endodontic referrals

Please give details of radiographs sent and radiograph reports:

Please consult our referral criteria before completing details below.

(Click on the link below to see referral criteria) http://www2.port.ac.uk/dental-academy/gdpreferrals/

Please tick the relevant referral type and complete the details.

PERIODONTICS	please tick					
Reason for referral (with	Diagnosis of periodontal disease (based on BSP staging and grading criteria):					
reference to published criteria	Smoking history:					
	Oral hygiene regime:					
	Draviaus history of pariodental treatments					
BPE	Previous history of periodontal treatment:					
	Prescription for the treatment to be undertaken by DCP students:					
EXTRACTION	please tick					
Reason for referral (with reference to published criteria)						
Relevant medical history:	Past extraction history:					
RCT	please tick					
Please specify tooth to be treated:	eason for referral (with reference to published criteria):					
-	ental history of tooth to be treated:					
Please provide details of current on-going treatment:						