oris
ORAL HEALTH CENTRE

Please complete the details of your patient referral
You can email the completed form to us at info@orisohc.co.uk

PATIENT DETAILS	
NAME (REQUIRED)	
DATE OF BIRTH	
ADDRESS	
PHONE NUMBER	
E-MAIL ADDRESS	
DOES THE PATIENT REQUIRE IN INTERPRETER? IF YES, PLEASE SPECIFY LANGUAGE	
REFERRING PRACTISE	
PRACTISE NAME	
DENTIST NAME	
ADDRESS	
POSTCODE	
PHONE NUMBER	
E-MAIL ADDRESS	
SPECIALIST REQUIRED	
SPECIALIST (PLEASE CHOOSE)	☐ Dental Hygienist ☐ Dentist ☐ Endodontist ☐ Facial Aesthetic Professional ☐ Oral Surgeon ☐ Orthodontist ☐ Periodontist
CLINIC REFERRAL	☐ Highgate ☐ Kensington
DETAILS OF CASE	
DATE OF REFERRAL	
SPECIALIST REQUIRED	
SPECIALIST NAME	
OUTCOME OF REFERRAL	
REFFERAL CONCLUSION DATE	
WAS THE PATIENT SATISFIED WITH THE OUTCOME OF THE CASE? IN NO, PLEASE GIVE DETAILS	