2 St Johns Road
Epping
Essex
CM16 5DN

01992 574 004
enquiries@croftsdental.co.uk

REFERRAL FORM

Thank you for considering Crofts Dental Practice for your referral needs. We will ensure that your patient is treated in a calm, caring and professional manner. We will provide quality dental care as requested by yourself, and return the patient to you once the referred treatment is completed.

Patient Details
Name ______________________________ DOB________________________________
ADDRESS ____
Tel Home__________________________ Tel Mob____________________________
Email______________________________

Referring Dentists Details
Name ________________________ Signature ____________________________
Practice Name & Address ____
Email _____________________________Tel __________________________________

Crofts Dental Practice is pleased to be able to offer referral services for Endodontics, Oral Surgery and Intravenous Sedation.

Treatment required

Endodontics ☐
____

Oral Surgery ☐
____

Please indicate if sedation required for endodontics or oral surgery ☐

Restoration under sedation ☐
____
(General Dentist)

Implants ☐
____

Description and details of referral, including any relevant medical history.
____
____
____

Thank you for your kind referral.

Please indicate if more referral forms required ☐

Alternatively please visit our website and download further forms.