KINGSCOURT DENTAL

REFERRAL FORM

PATIENT DETAILS

NAME: DOB:

ADDRESS:

EIRCODE:

TEL: EMAIL ADDRESS:

SERVICE REQUIRED

ORAL SURGERY EXTRACTION ☐	ROOT END SURGERY ☐
IMPLANT PLACEMENT ONLY ☐	GINGIVAL RECESSION TREATMENT ☐
IMPLANTS - PLACEMENT & RESTORATION ☐	OPG ☐
IMPLANT RETAINED DENTURE ☐	NOTES/COMMENTS
PRIVATE DENTURES (CDT) ☐	
ORTHODONTICS COMPREHENSIVE ☐	
ORTHODONTICS (STO) ☐	

RELEVANT MEDICAL HISTORY *(please include smoking)*

REASON FOR REFERRAL:	ASSESMENT & TREATMENT ☐	TREATMENT PLANNING ☐	URGENT CARE ☐

RIGHT LEFT

8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8

8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8

RIGHT LEFT

PRACTICE STAMP

REFERRING DENTIST

PRINT NAME:

SIGNATURE: DATE:

Dr. Laura McAtarsney BDS Hons QUB MJDF RCS Eng PG Dip ORTH
Dr. Vaidas VArinauskas PhD MDent Sc (Oral Surgery Specialist)
Damien O'Hare CDT

KINGSCOURT DENTAL PRACTICE
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