

The Hub Dental Practice 780 South Fifth Street, Central Milton Keynes MK9 2FX 775 Witan Gate, Central Milton Keynes MK9 2FW



01908 690326

reception@TheHubDentalPractice.com www.TheHubDentalPractice.com

Referral Letter for Treatment

Referring Dentist Details:		Referral For Treatment		
Dentist Name:		Please read and tick the boxes:		
GDC Number:		I am the Dentist/Hygienist.		
Dentist Email: Practice Name and address:		I am referring the patient for the reasons outlined below.		
		Dentist/Hygienist Signature:		
		Date		
		Please note that patients are expected to pay on the day for their examination/treatment.		
		X-rays to be sent to Xrays@TheHubDentalPractice.com		
Practice Tel. No Practice Email:		Would you like us to provide?		
		Second Opinior Treatme		
		Reason for referral:		
Patient Details:				
Name:	DOB:			
Address:				
Home Tel:				
Mobile Tel:				
Email:				
Any other Notes:				
We will take a full MH and ask the patient to sign consent forms prior to an examination/treatment. The referring dentist can request a copy of these documents.				