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 Orthodontic Treatment

Referring Dentist Details:

Dentist Name:

GDC Number:

Dentist Email:

Practice Name and address:

Practice Tel. No

Practice Email:

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.

Referral For Orthodontic Treatment

Please read and tick the boxes:

☐ I am the Dentist/Hygienist.

☐ I am referring the patient for the reasons outlined below.

Dentist 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

Would you like us to provide?

Second Opinion ☐ Treatment ☐

Reason for referral: