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:	☐ I am referring the patient for the reasons outlined below.
Practice Name and address:	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	Would you like us to provide?
Practice Email:	Second Opinion☐ 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.	