# Bridge House Dental Practice

## REFERRAL FORM

377 Norwich Road, Ipswich, Suffolk IP1 4HA · 01473 742142 · info@bhdp.co.uk

## REFERRING DENTIST

FULL NAME

JOB TITLE

GDC NUMBER

PRACTICE NAME

PRACTICE ADDRESS & POSTCODE

EMAIL

CONTACT NUMBER

## TYPE OF REFERRAL (TICK ALL THAT APPLY)

- ☐ Oral Surgery
- ☐ Dental Implants
- ☐ Endodontics
- ☐ Periodontics
- ☐ Complex Restorative

## PATIENT DETAILS

TITLE

FIRST NAME

SURNAME

DATE OF BIRTH

CONTACT NUMBER

EMAIL

ADDRESS & POSTCODE

## RELEVANT MEDICAL & DENTAL HISTORY

INCLUDE MEDICATIONS, ALLERGIES, EXISTING CONDITIONS, RELEVANT DENTAL HISTORY

## REASON FOR REFERRAL

DESCRIBE THE CLINICAL PICTURE AND WHAT YOU WOULD LIKE BRIDGE HOUSE TO REVIEW

## RADIOGRAPHS & IMAGING

Number of radiographs attached: _____

Please email radiographs, CBCT files or clinical photos separately to info@bhdp.co.uk

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*Return this form to info@bhdp.co.uk or post to Bridge House Dental Practice, 377 Norwich Road, Ipswich, Suffolk IP1 4HA*
*We will confirm receipt within one working day and update you on the referral outcome.*