smile SUFFOLK

people-centred dental care

Smile Suffolk – Ipswich

Referral Centre
No.1 Woodbridge Road East, Ipswich, Suffolk IP4 5QP
t. 01473 728886
e. hello@smilesuffolk-ipswich.co.uk
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Referrals form

Referring dentist:

Practice name:

Dentist name:

Work telephone:

Mobile telephone:

Email:

Date of referral:

Patient details:

Full name:

Date of birth:

Address:

Work telephone:

Mobile telephone:

Email:

Is the patient nervous about having dental treatment? ◯ Yes ◯ No

May we contact the patient to arrange an initial consultation appointment? ◯ Yes ◯ No

Relevant medical history:

Reason(s) for referral (please tick where relevant):

◯ Smile Makeover ◯ Wear Case ◯ Implant(s) ◯ OPG ◯ Sedation

◯ Complex Restorative Case ◯ CT Scan ◯ Sinus/bone Graft(s) ◯ Extraction

Please provide more detailed information:

Radiographs

Could you email us any relevant radiographs? ◯ Yes ◯ No

Area(s) to be treated:

RIGHT	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	LEFT
	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	

OUR PROMISE TO YOU
We will only treat patients based on the issue(s) they have been referred to us for. If your patient requires additional treatment, we will speak to you in the first instance, to ensure that you remain central to all their treatment needs.