

PATIENT:

REASON FOR REFERRAL:

DATE:



## IMPLANT/SURGICAL REFERRAL PRO-FORMA

Dr Scher sets aside clinic time to ensure your referral patients are seen promptly. Please have your nurse / receptionist phone us to arrange an appointment for your patient today to limit waiting times and help us serve you better.

Referring Practitioner  Date

Address

Phone  Fax

Appointment made for  Do you wish us to contact the Patient? Y  N

Patient Name  D/O/B

Contact Address

Phone  Is this your first referral to our practice? Y  N

Main Complaint / Reason for Referral

Investigate and Treat  Working as a Team  Opinion Only

Relevant Medical Details

Anxious

Clinical Details (optional):

Problem Areas 

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

 Rads Enclosed? OPG  PAs  Others   

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

Further Details

Please post or fax this form to us. Thank you for your referral.