93 Robin Hood Way, London SW15 3QE T. 02086179180 E. reception@cherrytreedentistry.co.uk

Oral Surgery Referral Form

Patient Information	
Name	Address line 1
D.O.B	Address line 2
Home Tel	City/Town
Mobile	Post code

GP Details	
GP Name	GP Address line 1
Clinic Name	GP Address line 2
Clinic Tel	Post code

Referring Practitioner Information	
Name	Address line 1
GDC number	Address line 2
List number	City/Town
Signature	Post code

Medical/Dental history, please include ASA category

Diagnosis/Reason for referral

Treatment required, please tick

Surgical removal of retained roots	Lingual Frenectomy
Surgical removal of wisdom tooth	Labial Frenectomy
Surgical removal of other tooth	Coronectomy
Tooth apex surgery	Implant Treatment

Other pathology (please specify) ……..

Requested mode of anaesthesia, please tick

Local Anaesthesia IV Sedation Inhalation Sedation

Radiographs enclosed Yes No

Date of referral: