

ORTHODONTIC REFERRAL FORM

To :

From (Referring Dentist's Stamp)

*Dr. David G. Horobin and Associates
Specialists in Orthodontics,
39 Chapel Road,
Bexleyheath,
Kent. DA7 4HW*

*Tel. 020 8303 6836
Fax 020 8303 4020
E-mail: reception@bexleyortho.co.uk*

Date

Dear David,

Re: Patient's Name (Mr Mrs Miss).....DOB.....

Patient's Address

Post Code Patient's Telephone

Would you please examine and treat this patient's orthodontic condition as appropriate.

I understand that he/she will continue to attend my own Practice for routine dental treatment, including orthodontic extractions.

Yours sincerely,

.....
(Signature of referring Dental Surgeon)

Special Remarks:

(Please include any information you think may be of assistance)

Please tick if you require further supplies of this form

Please ensure all parts of this form are fully and accurately completed - Thank you.