NHS
Gloucestershire Hospitals
NHS Foundation Trust

Name:	
Date of Birth:	DD / MM / YYYY
MRN Number:	
NHS Number:	
(OR AFFIX HOSPITAL LABEL HERE)	

Routine Dento-Alveolar Referral Form

www.gloshospitals.nhs.uk/glosmaxfax

Please advise your patients that treatment will most likely be performed at Cirencester Hospital. Please tick [ ] to confirm patient informed.

Patient details	
Name	D.O.B
Gender Male ❑ Female ❑	NHS No (Mandatory)
Address Postcode	
Home telephone	Mobile telephone
Diagnosis and treatment requested. **Please state why this procedure cannot be performed in primary dental care.**	
All medical conditions, allergies/reactions and medications	

Radiographs **www.gloshospital.nhs.uk/glosmaxfax/xrays**

Good quality radiographs MUST accompany this referral in accordance with the specification detailed on our website above. If the radiographs are of insufficient quality, or are not enclosed, we will regretfully return the referral to you until such time as we are in receipt of a suitable radiograph.

Name of referring dentist (print name)	Date DD / MM / YYYY
Address of referring dentist	