The Parkway
Private Clinic

Parkway Clinic
Lamberts Road
SA1 Waterfront
Swansea
SA1 8EL
Tel: 01792 455780
Email: webmail@parkwayclinic.co.uk
Web: www.parkwayclinic.co.uk

PRIVATE SPECIALIST REFERRAL FORM

Please PRINT in BLOCK capitals

PATIENT DETAILS:

Name: …….....

Date of Birth: ……..... Male / Female

Address: …….....

…….....

…….....

Post Code: .....
Home Telephone No: .....
Mobile Telephone No: .....
Email address: ……

REASON FOR REFERRAL
(please tick):

Implants	☐
Endodontics	☐
Hygienist	☐
Tooth Whitening	☐
Prosthetics	☐
Crown & Bridgework	☐
Tooth Wear	☐
Oral Surgery	☐
Oral Medicine	☐
Facial Pain/TMJ	☐
Medico-Legal	☐

Other (please state)

REFERRER DETAILS:

Referring Practitioner: …….....

Practice Address: …….....

…….....

…….....

Practice Telephone No.: …….....

Practice email address: …….....

Date of Referral: …….....

FOR TREATMENT UNDER:

Local Anaesthetic ☐

Local Anaesthetic / Sedation ☐

General Anaesthetic ☐

All referrals must be returned to Parkway Clinic, Lamberts Road, SA1 Waterfront, Swansea, SA1 8EL

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REFERRAL DETAILS:
(Please give as much information as possible, e.g. any patient requirements)

MEDICAL HISTORY:
Relevant medical history (including current medication)

ENCLOSURES:

Radiographs	
Study models	
Diagnostic wax-up	
Other (please state)	
None	

I confirm I have the patient's consent to share this information (please tick)	☐

Name of Practitioner: ……
(Please print)

Signature of Practitioner: …… **Date:** ……

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