

# MINT

## DENTAL HYGIENE

### Referral Form

Patient Name ..... D.O.B .....

Address .....

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..... Postcode .....

Telephone No ..... Mobile No .....

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Any Medical Conditions .....

Any X-ray copies No. of .....

If necessary, could referring dentist give permission for Local Anaesthetic to be used?

Articaine/lidocaine .....

Citanest with Octapressin .....

Permission to apply fluoride varnish for sensitivity Y / N

Permission to recommend higher fluoride toothpaste Y / N

Name of referring Dentist .....

Address of Practice .....

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Thank you very much for your referral. I will keep you updated with the patients progress.

Diane Washington RDH