

REFERRAL FORM FOR HYGIENIST SERVICES

REFERRING DENTIST

Name _____
Address _____
_____ Postcode _____

Date _____
Tel _____
Fax _____
Email _____

PATIENT DETAILS

Name _____
Address _____
_____ Postcode _____

DOB _____
Home _____
Work _____
Mobile _____

Relevant Medical History _____

BPE: Basic Periodontal Examination

- Code: 0 No bleeding on probing
1 Bleeding on probing (BOP), no pockets 4mm>
2 BOP, calculus or other plaque retentive factors no pockets 4mm>
3 Pockets 4 and 5mm
4 Pockets at least 6mm
* Furcation

Treatment Required (please tick)

- Appointment type 1 (BPE 0 – 2)**
- Discuss treatment
 - Full mouth scale and polish
 - Oral hygiene instruction
 - Arrange further appointments with patient as necessary

- Appointment type 2 (BPE 3 – 4)**
- Discuss treatment
 - Full mouth periodontal charting
 - Oral health instruction
 - Initial non surgical therapy with local anaesthesia if required
 - Arrange further appointments with patient as necessary

- Appointment type 3 supportive periodontal therapy** for a period of
- 1 yr 2 yrs 3 yrs

Prescription - Hygienists must be provided with a written prescription from the referring dentist to legally be able to treat patients. Please advise what treatment the patient requires.

Does the patient normally require local anaesthesia for a routine scale and polish. Yes No

Radiographs included:- Left Bitewing Right Bitewing Periapicals (number)

SIGNATURE OF REFERRING DENTIST..... DATE

Please send this form to :-
Cleveland Cosmetic and Dental Implant Clinic, Greenfields House, Wellburn Road, Fairfield,
Stockton-on-Tees. TS19 7PP Tel 01642 570147 Fax 01642 570870
www.clevelandcosmetic.co.uk