NHS
Tower Hamlets

Specialist Periodontal Service Referral Form

Patient Name and Address *(Please check with patient if this is correct)* **Post Code:** **Daytime telephone:** **Mobile:** **E-mail:** **Patient DOB:** **Date of Referral:** **Referred to:** Brace ☐ Waterside ☐	**Referring Practitioner (stamp)** **Signature of Dentist:** **Name and Address of GP**

Reason for Referral / Preliminary treatment carried out by GDP
(Please refer to acceptance criteria. No referral will excepted unless the patient has been provided with initial treatment and supportive therapy)

Recent radiographs ☐ **Oral Hygiene**: Excellent ☐ Good ☐ Fair ☐ Poor ☐
(*Relevant radiographs must be enclosed)*

Relevant Medical History/Modifying Factors	**BPE Score**

PCT charge collected (£): **Yes** ☐ **Amount** _____ **No** ☐ **Exempt** ☐

Provider Use Only

Date of first Appointment	
Dates of Treatment	
Returned (inappropriate referral)	
Referred to hospital	