Cambria Dental

Referral Form

Please complete **all fields** below

Patient Details

Name

Address

Postcode

Date of birth

Telephone No. (daytime contact)

Referring Dentist

Name

Address or practice stamp

Telephone No.

Relevant Medical & Drug History

Service Required (please tick)

- ☐ Oral Surgery
- ☐ Dental Implants
- ☐ Periodontal Assessment/Treatment
- ☐ Other

☐ IV Sedation Required

Important – If you are referring a patient for treatment under IV sedation please sign to confirm that they have been appropriately counselled at the time of referral.

Signed Referring GP

Reason for Referral

Radiographs

If radiographs are enclosed, please indicate the number and type.

Please return form to:

Cambria Dental Practice, 25 Eversley Road,
Sketty, Swansea. SA2 9DB.
referrals@cambriadental.co.uk