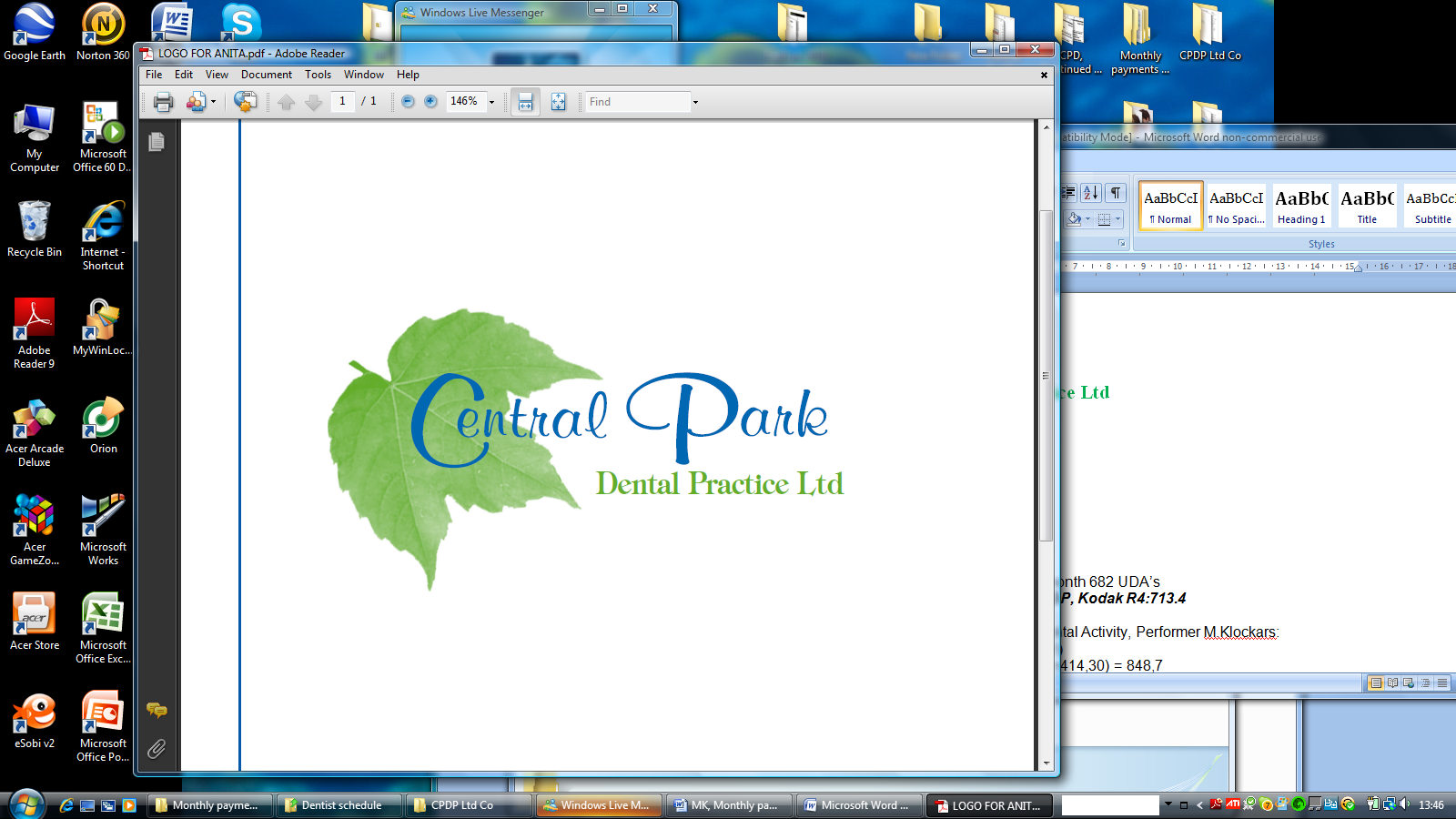
**Address:15 Milehouse Road, Plymouth, PL3 4AD**

**Tel: 01752-500959 Fax: 01752-500463**

**Email:** [**cpdental@btconnect.com**](mailto:cpdental@btconnect.com)

**Website: www.centalparkdentist.co.uk**



**REFERRAL form**

Referring DENTIST

Name: .........................................................................................

Address:...................................................................................................................

....................................................................... Post code: .........................

Tel: ..............................................................Fax:.....................................................

Email:..............................................................................

PATIENT

Name: .........................................................................................DOB:....................

Address:...................................................................................................................

....................................................................... Post code: .........................

Tel: ...........................................................Mobile....................................................

Email:..............................................................................

REASON for referral: (please circle)

Implantology Somnowell appliance (antisnoring /sleep aphnea)

Periodontology Clear Aligners

Wisdom tooth removal Aesthetic dentistry Other........................

Name of Clinician: Dr Anita Norgren-Alarcon, DDS

Dr............................................

Patient symptoms and complaint:...........................................................................

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.................................................................................................................................

Clinical findings:.......................................................................................................

.................................................................................................................................

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Medication:...............................................................................................................

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Treatment proposed / required / requested:...........................................................

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.................................................................................................................................

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Enclosures: (please tick)

X-rays:.................................................Photos - intraoral ...................... / extraoral..................

Study models:...............................................................................................................................

Other: ..............................................................................................................................................

Signature:.........................................................................................................................................

Printed Name:..................................................................................................................................

Date:....................................................**Please send to: Central Park Dental Practice Ltd**

**15 Milehouse Road, Plymouth PL3 4AD**