**FortwilliamClinic**

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Ballymena, BT43 5EN
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# Patient Referral Form

Appointment Date: (If already booked)

Appointment Time: (If already booked)

Patient Name:

DOB:

CHI:

Address Line 1:

Address Line 2:

Mobile/Tel No#:

Relevant Medical History:

Would you prefer this patient to be seen by a particular clinician? yes / no

If Yes which clinician?

RA SEDATION (please circle): yes / no

IV SEDATION (please circle): yes / no
*(Patients having I.V. sedation should fast for 4 hours prior to appointment and be accompanied by a responsible adult, who can take them home and look after them for approx. 6 hours following treatment.)*

Procedure:

Teeth:

Payment Source: NHS / Private

Referring Dentist Name:

Referring Dentist Email:

Signature:

Date: