# Specialist Referral Form

**Specialist** (please tick)

Dr Anish Shah (Oral Surgeon)

Dr Robert Ward (Periodontist)

Dr Wail Girgis (Implantologist)

Dr Rudi Swart (Sedation)

**Patient details**

Mr / Mrs / Miss / Ms / Dr (please circle)

Patient Name

DOB

Telephone

Mobile

Patient Address

**Referring practitioner**

Dentist Name

Practice Name

Telephone

Email

Address

**For a consultation regarding** (continue on the reverse if needed)

**Please enclose radiographs** (if digital please email to **info@dentalsmilestakeley.co.uk**)

Please turn over

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This form can be completed or downloaded at **www.dentalsmilestakeley.co.uk/referrals**

Hard copies can be ordered by **telephone on 01279 879526** or **email info@dentalsmilestakeley.co.uk**