



REFERRAL FORM FOR COMPLEX PROCEDURES

Endodontic and/or surgical extractions

To make a referral for an endodontics and/or surgical procedure, please complete the form below and save it to your computer before attaching it and sending to Blue Pearl Dental Care by email at: **info@bluepearldental.com**.

If you have difficulty completing this form, please enter data manually, print and post the completed form to: **Blue Pearl Dental Care 126A Seven Sisters Road, London N7 7NS**.

Patient Details

Title: Patient's name:

Patient's address: Postcode:

Date of Birth: Gender:

Tel: Mobile:

Email: Referral Date:

Medical History, disability

Medication

Referring Dentist Details

Dentist's name:

GDC No:

Practice address: Postcode:

Email:

Referring Details

Please select one of the following treatments:

Complex Endodontic treatment

Complex surgical extraction

Please explain the reason for referral and information that you consider useful for the treatment.

Select the type of service required:

1 root canal treatment	
2 roots canal treatment	
3 roots canal treatment	
Additional canal	
Re RCT Additional fee	

Complex Extraction	
Conscious sedation	

Referring Details Cont.

Does your patient need conscious sedation? Yes No

Can you provide patient x-rays? Yes No

If no, will be an additional cost. (CBCT scan £120) (OPG £60)

If yes, please select the options that apply.
 OPG CBCT SCAN

Fees

Please refer to the price list below for information on our services

Service	Price
1 root canal treatment	£420
2 roots canal treatment	£550
3 roots canal treatment	£730
Additional canal	£60
Re RCT Additional fee	£110
Complex Extractions	£395
Conscious sedation (per hour)	£300

Please tell us your preferences

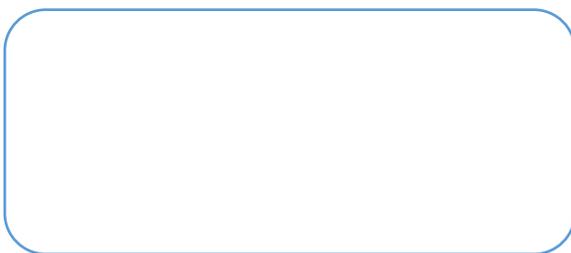
Please Note:

- You will receive an email confirming that we have received your referral, and we can provide the service.
- Once the referral is accepted, we will contact the patient to schedule the appointment and let them know important recommendations before the procedure.

Important information: it is essential that you complete all sections of this form in full.

The referring practice will be responsible for ensuring the clinical evaluation takes place and is properly recorded.

Signature of referring dentist:



If you do not have a digital version of your signature available, please type your name in the signature area to the Left and check the box above to acknowledge the inclusion of all data required for us to proceed.