Specialist Referral

Please send this form by post or email to
orthosolutions-tc@idhgroup.co.uk

Unit A
Moor Allerton District Centre
Leeds
LS17 5NY
Tel 0113 288 8995/7
Fax 0113 266 1984

Date of referral : _____

Patient Details: Patient details: (BLOCK CAPITAL LETTERS PLEASE)

Title: (Mr/Miss). _____

First Name: _____

Surname. _____

Male ☐ Female ☐ Date of birth: _____

Address: _____

Town: _____

Postcode: (ESSENTIAL _____

Telephone:

DAYTIME _____ MOBILE _____

NHS Number: _____

Dear Orthodontists

Please could you see and treat appropriately the above patient who has an orthodontic problem. I would like the patient to have a **Private consultation** (Please delete as appropriate – private treatment is automatic for aged 18 or over)

Please specify here if you wish to be seen by a specific orthodontist

_____

Please note this may lead to delays in treatment, if NHS treatment is requested.

Yours Sincerely

Please print Dentist name clearly here _____

Relevant Medical History:

Observations:

Practice Details