**CDT Referral Form**

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| Planned Treatment: (Please tick) |  Patient Name:  |
| Cobalt Chrome P/-  | Cobalt Chrome -/P | Cobalt Chrome P/P |
| Acrylic P/- | Acrylic -/P | Acrylic P/P |
| Flexible P/- | Flexible -/P | Flexible P/P |
| Acrylic F/- | Acrylic -/F | Acrylic F/F |
| Implant Retained F/- | Implant Retained -/F | Implant Retained F/F |
| Addition of tooth to existing Denture |  | Other(please specify) |
| Intra/extra oral examination carried out: Y / N (comments/concerns) |
| Patient is suitable for treatment: Yes / No (to be completed by patient’s dental practitioner) |
| Additional Information: (to be completed by patient’s dental practitioner) |
| Dental Practitioner Name: |  |
| Dental Practitioner Signature: |  |
| Practice Name & Address: |  |
| Signature: |
| Date: |  |
| Clinical Dental Technician: | James Baker (GDC – 151659) |