**A close-up of a logo

Description automatically generatedCDT Referral Form**

|  |  |  |  |
| --- | --- | --- | --- |
| 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) | |