TRACEY BELL®
DENTAL AND AESTHETIC MEDICAL CLINIC

Head Office
The Tracey Bell Clinic
Kensington Road
Douglas
IM1 3PE

Call Centre: 01624 613323

CT REFERRAL FORM

- Patient Name: _____
- Phone No: _____

- Referring Doctor Name: _____
- Phone No: _____
- Address: _____

- **Relevant Medical History:**

_____

_____

_____

- **Reason for Referral**

_____

_____

_____

_____

_____

_____

- **Planned Restoration*:**

(*Please advise if you prefer a temporary, GIC or amalgam restoration or if a post space is to be prepared)

_____

_____

_____

_____

_____

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- **Radiographs / Photographs:**

  ◯ Please take / send copy
  ◯ Patient will bring copy
  ◯ I will send ◯ Please return ◯ No return needed

- **Comments:**

_____

_____

_____

_____

- **Please**

◯ Call me before seeing the patient

◯ Call me after seeing the patient

◯ Alternate re-care appointments

◯ Do all re-care

- **REFERRING DENTIST:**

General Dentists name: _____

Signature: _____

Date: _____/_____/_____