ALL fields are mandatory. If the form is not completed or illegible it will be rejected

|  |  |
| --- | --- |
| Patient Surname |  |
| Given names |  |
| NHS Number |  |
| Date of Birth |  |
| Gender |  |
| 1st line of address |  |
| Postcode |  |
| Patient Contact No :  |  |
| Dental Practice |  |
| Dentist |  |
| Dentist Signature |  |
| Clinical information(Reason for request) |  |
| Examination(s) Required |  |
| Urgency |  |
| Other Information Special requirements/holidays etc)  |  |

Please use nhs.net email and send to

Uhs.gprefferal@nhs.net