

TLC referral form

Referring dentist's details

Name	
Practice address	
	Postcode
Practice telephone	Fax
Email	

Patient's details

Name	Date of birth
Address	
	Postcode
Telephone	Mobile
Email	



TLC

the light-touch clinic

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Diagnosis and referral information

Please include reason for referral and specific problem areas.

Relevant medical history

Please include any radiographs which may help in evaluating the patient.
We will return them to you after use.

- Basic periodontal examination (Code 4 requires full periodontal assessment.)
- Full periodontal assessment (If necessary, please refer to periodontal specialist.)
- Scale and polish with OHI
- Non-surgical periodontal therapy (detox therapy) please specify area _____
- Root surface instrumentation – please specify area _____
- Desensitisation – please specify area _____
- Fluoride application – please specify area _____
- Fluoride toothpaste
0.62% Duraphat 2800 1.1% Duraphat 5000
- Supportive periodontal therapy
1 Year 2 Years 3 Years
- Other requirements – please specify area _____
- Please X-ray affected area
- Local anaesthesia Maximum number of cartridges per visit _____
- Lignospan Scandonest Plain Septanest

Under current regulation, referrals to a hygienist can be valid for 1–3 years.

Please indicate by signing below that you are happy for the above treatment to be carried out.

When would you like the patient to be seen again by you?

Signed (referring dentist)