

REFERRAL TO DENTAL HYGIENIST

Patient Name:
Patient Address:

Patient DOB:
Patient Telephone:

BPE Date of next recall due
(we will continue to treat this patient until then, to
continue after this date will require another prescription)

Please provide the following: Scale and polish gross scale

No of visits Use LA MH alert
TBI Flossing Dietary advise
Comments of further instructions

Referring dentist name, address,

Telephone number:
GDC number:
Signature:
Date: