NIAMH BOYLE

B A B D E N T S C M F D F F D (O S O M) R C S I

PRACTICE LIMITED TO ORAL SURGERY

OFFICE 5, QUAYSIDE SHOPPING CENTRE, WINE STREET, SLIGO.
TELEPHONE: 071 9150820 EMAIL: nb.oralsurgery@gmail.com

REFERRAL FOR ORAL SURGERY

DENTIST DETAILS

Name: ..... Date: .....

Address: .....

Telephone: ..... Fax: .....

Email: .....

PATIENTS DETAILS

Name: ..... D.O.B.: .....

Address: .....

Telephone: ..... Mobile: .....

Email: .....

RELEVANT MEDICAL HISTORY

REASON FOR REFERRAL

RADIOGRAPH ENCLOSED (TICK RELEVANT BOX) ☐ Yes ☐ No

(Radiograph will be returned at the end of treatment)

☐ LOCAL ANAESTHETIC ☐ LOCAL ANAESTHETIC AND INTRAVENOUS SEDATION

ANY ADDITIONAL INFORMATION

THANK YOU FOR YOUR REFERRAL