The Brookmans Park Dental Practice

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REFERRAL TO DENTAL HYGIENIST

Please complete this form to enable our hygienist to carry out your prescribed treatment plan.

Date of most recent examination ___/___/____

Relevant MH: _____
_____

Treatment in progress _____

BPE

Treatment required (tick relevant)

Routine full mouth scale & polish

Quadrant scaling

Root Surface Instrumentation

Stain Removal/ prophy jet air polish system

To be used as required (tick relevant)

Topical anaesthetic

Local anaesthetic

Desensitising agents

Maintenance intervals
Date of next examination

Practice Stamp