

Date:

Dear Robert

Patient name _____

Address _____

D.O.B _____

I wish to refer the above patient to Hollins Denture Clinic for the provision of denture services.

Please provide denture services according to the following general directions.

Maxillary Mandibular

Upper material (please circle) Acrylic Chrome-Cobalt Flexible Other

Lower material (please circle) Acrylic Chrome-Cobalt Flexible Other

Upper (please circle) Tissue borne Tooth borne

Lower (please circle) Tissue borne Tooth borne

Or

Please make to exact prescription written in the box below:

Teeth of doubtful prognosis (please circle)

R 8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8 L
 8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8

Teeth to be extracted (please circle)

R 8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8 L
 8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8

Other relevant information

Signed: