Praxis Dr. med. dent. Amina Munir

Referral form

Patient

Surname/ First name: Date of birth:

Street, No.: Telephone number:

Postcode/ town: Email address:

Patient should be contacted via: phone ☐ post ☐ email ☐

Patient will get in touch: ☐

Practice

Physician: Practice:

Street, No.: Telephone number:

Postcode/ town: Email address:

Referral for

Please check if applicable

Dental examination required before:

Planning a pregnancy/ IVF treatment ☐

Radiotherapy ☐

Treatment with bisphosphonates ☐

Immune suppressive treatment ☐

Suspected dental infection as a cause of:

Acute or chronic sinusitis single-sided ☐ bilateral ☐

Headaches single-sided ☐ bilateral ☐

Swollen lymph nodes, affected region

Other causes for referral:

Additional remarks:

Dear Physicians/ Colleagues,

Please do get in touch via phone call or email, if you would like to discuss the case first or if examination and treatment are required urgently.

The filled form along with any relevant documents may be sent via email or post.

Thank you for the trustful collaboration.

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