



Confidents Denture Clinic

19 Albert Road, Harborne
Birmingham B17 0AP
Telephone: 0121 426 3500

PATIENT TREATMENT PLAN FOR CDT

Re:

Thank you for referring the above named patient to me.

I saw _____ at my clinic on _____ and have undertaken some treatment for **him/her**.

As part of **his/her** ongoing treatment **he/she** now requires:
(please tick as appropriate)

Upper Partial Denture

Lower Partial Denture

Complete Upper Denture

Complete Lower Denture

Other treatment required to secure oral health (Please Specify)

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Any particular or specific instructions related to the denture provision, which may include advice for design or materials used in construction.

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I am sending the patient back to you, with a prescription for completion of the above noted treatment. A copy of **his/her** relevant records including a chart and radiographs where appropriate is attached.

Signature..... Date

Name Qualification (s)