PATIENT TREATMENT PLAN

Re:…… D.O.B……

I have completed/are undertaking any necessary treatment *(please delete as appropriate)* for the above named patient.

To complete this treatment the following is now required:- *(please tick as appropriate)*

Upper Partial Denture ☐

Lower Partial Denture ☐

Complete Upper Denture ☐

Complete Lower Denture ☐

Other (please specify)……

Any particular or specific instructions related to the denture provision :-

……

……

……

I am now sending the patient back to you for completion of their treatment. A copy of the relevant records including a chart and radiographs where appropriate are attached.

Name …… **Practice Details & Stamp (important)**

Date……

Signature……

Qualifications……

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