



Patient Referrals

At **Skydent**, we pride ourselves on offering services that go beyond the scope of most dental laboratories. Led by Martin Coldicott (Clinical Dental Technician), our team combines technical precision with clinical excellence to deliver high-quality results and exceptional patient care.

Why Refer to Skydent?

We understand the increasing demands placed on dental surgeries. That's why we provide a referral-based denture service that helps free up valuable clinical time, allowing your team to focus on more complex or higher-value treatments.

Martin is a highly experienced CDT with direct access to edentulous patients and a trusted reputation across the region. For dentate patients, we accept referrals directly from your practice. Whether your clinicians are facing a backlog of denture cases or simply prefer not to take on denture work, we are more than happy to support you and your patients.

Services Available:

- **Full Clinical Denture Service**

Start-to-finish denture treatment for referred patients (Direct access for edentulous patients)

- **Same-Day Services** — perfect for emergencies or convenience, all handled within the same day.

- **Repairs** — Ready in **1 hour**
- **Additions & Relines** — Completed within **3 hours**
- **Acrylic Dentures** — Full process from impression to fit in just **7 days**
- **Chromes/Flexi** — 2/3 weeks

If you would like to refer a patient or discuss how **Skydent** can support your practice, please don't hesitate to contact us. We look forward to working with you. We have enclosed a referral form for your ease:



Martin Coldicott Clinical Dental Technician
GDC Number - 139238
26 Market street, Stourbridge, DY8 1AG
Email: info@skydent.co.uk
Tel: 01384736439
Mobile - 07432404363

REFERRING DENTIST DETAILS:

Dentist Name:..... Practice Name.....
Practice Address:.....
..... Post Code.....
Phone Number:..... Email

PATIENT DETAILS:

Name:..... DOB.....
Address:.....
..... Post Code.....
Phone Number:..... Email

RELEVANT MEDICAL HISTORY

LEVEL OF REFERRAL

Referral (please tick as appropriate)

☐ Upper ☐ Lower ☐ Partial ☐ Complete ☐ Implant retained

Additional Information relating to the denture provision: (please note, any recommendations will be subject to denture assessment and patient's expectation).

Dentist signature..... Date.....

Thank you for your referral, we will contact the patient to offer an assessment and will keep you updated with any proposed treatment.