

For your Dentist



Elphinstone Wing, Carberry, Musselburgh, EH21 8PW

0131 653 6767

[admin@healthlink360.org](mailto:admin@healthlink360.org)

Dear Colleague

Many thanks for agreeing to see this patient. They are embarking on an overseas assignment with a registered charity to a potentially resource- poor and demanding location.

As the specialist health advisor for their sending agency, HealthLink360 requires this individual to have had a routine dental check. We believe they are due to have one and I would be very grateful if you would carry this out. Please would you complete the form provided and give this sheet back to your patient.

HealthLink360 is a UK charity specialising in medical, psychological and travel health care, primarily for the Mission, Humanitarian and Overseas Development sectors [www.healthlink360.org](http://www.healthlink360.org). Our team of doctors, psychologist, counsellors and nurses operate a face to face and remote specialist service from our base on the outskirts of Edinburgh for a wide variety of individuals and Agencies seeking to make a difference all around the world.

We are grateful for your help in supporting this individual in their overseas assignment.

Yours faithfully

A handwritten signature in blue ink that reads 'Keith J Russell'.

**Dr Keith Russell** MBChB DRCOG DGM FRCGP  
**Co-ordinator of Medical Services, HealthLink360**

|   |                       |                           |  |
|---|-----------------------|---------------------------|--|
| Patient Name  |                       | Date of Birth             |  |
| Date of dental check up                               |                       |                           |  |
| Result  |                       |                           |  |
|   |                       |                           |  |
| Is follow up treatment required within the next year? | Yes/No                |                           |  |
|   | If yes please specify |                           |  |
|   |                       |                           |  |
| Health Professional's details                         |                       |                           |  |
| Name  |                       | Practice Stamp or Address |  |
| Professional Status                                   |                       |                           |  |
| Contact Number  |                       |                           |  |
| Signature   |                       | Date                      |  |