



Implant Referral Form

PRACTICE DETAILS

Referring Practice	Date
Practice Address	
Referring Dentist	Tel
Email	

PATIENT DETAILS

Patient Name	Date of Birth	
Patient Address		
Tel Home	Tel Work	Mobile
Email	Is this referral urgent?	<input type="radio"/> Yes <input type="radio"/> No

REFERRAL INFORMATION (Please tick all relevant boxes)

Reasons for referral <input type="radio"/> Full mouth reconstruction <input type="radio"/> Implant assessment, placement & restoration <input type="radio"/> Implant placement & refer back for restoration <input type="radio"/> Opinion only <input type="radio"/> Single tooth missing <input type="radio"/> Multiple teeth missing <input type="radio"/> Totally edentulous jaw(s)	Types of implant retained restoration which have been explained to the patient <input type="radio"/> Single tooth implant <input type="radio"/> Partial overdenture <input type="radio"/> Full restorative case including perio & implants <input type="radio"/> Implant supported bridge <input type="radio"/> Full overdenture	Is your request for implant placement only? <input type="radio"/> Yes <input type="radio"/> No Has the patient been made aware of the level of investment that may be required? <input type="radio"/> Yes <input type="radio"/> No
Affected areas <input type="radio"/> Upper <input type="radio"/> Lower <input type="radio"/> Both		

BRIEF HISTORY (Comments about this referral)

DIAGNOSTIC AIDS (Please tick all relevant boxes)

In order to minimise unnecessary exposure please indicate which radiographs you are sending with the referral

OPG PA's Other Radiographs

Please be assured that we will neither approach nor accept your patient for non-referred treatment.