



Implant Referral Form

REFERRING DENTIST

Name: _____ Tel: _____
 Address: _____ Fax: _____
 _____ Email: _____
 Post code: _____ Date: ____ / ____ / ____

PATIENT DETAILS

Name: _____ Home Tel: _____
 Address: _____ Work: _____
 _____ Mob: _____
 Post code: _____ D.O.B.: ____ / ____ / ____

Is this referral urgent? Yes No

RELEVANT MEDICAL HISTORY (Any additional comments about this referral)

TYPE OF REFERRAL (Please tick)

Patient new to your practice Regular Attender

REASON FOR REFERRAL (Please tick/specify)

Consultation Single Tooth Implant Multiple Implants

CLINICAL SITUATION (Please tick/specify)

Failing Endodontics Failing Crown/Bridge Work Potential Root Fracture
 Unrestorable Teeth Unstable Denture Long Standing Space Closure
 Aesthetics

TOOTH NOTATION

RIGHT

18 17 16 15 14 13 12 11

LEFT

21 22 23 24 25 26 27 28

48 47 46 45 44 43 42 41

31 32 33 34 35 36 37 38

GENERAL

Has the patient been made aware of the level of investment that may be required? Yes No

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