

Call Centre: 01624 613323

**DENTAL IMPLANTS REFERRAL FORM**

● Patient Name: \_\_\_\_\_

● Phone No: \_\_\_\_\_

○ Referring Doctor Name: \_\_\_\_\_

○ Phone No: \_\_\_\_\_

○ Address: \_\_\_\_\_

● **Relevant Medical History:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

● **Reason for Referral**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

● **Planned Restoration\*:**

(\*Please advise if you prefer a temporary, GIC or amalgam restoration or if a post space is to be prepared)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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● **Radiographs / Photographs:**

- Please take / send copy  
 Patient will bring copy  
 I will send     Please return     No return needed

● **Comments:**

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● **Please**

- Call me before seeing the patient  
 Call me after seeing the patient  
 Alternate re-care appointments  
 Do all re-care

● **REFERRING DENTIST:**

**General Dentists name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_