

# implant / restorative referral form

## Practice Details

Referring Practice: \_\_\_\_\_ Date Referred: \_\_\_\_\_

Referring Dentist: \_\_\_\_\_

## Patient Details

Patient's Name: \_\_\_\_\_ Email: \_\_\_\_\_

Patient's Address \_\_\_\_\_

Telephone Numbers: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Mobile: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Is this referral urgent?  Yes  No

## Implants - Reason for Referral (please cross all relevant boxes)

- |   |  |
|---|--|
| <input type="checkbox"/> Assessment/Advice/Treatment planning only            | <input type="checkbox"/> Multiple units                          |
| <input type="checkbox"/> Implant surgery and associated restorative treatment | <input type="checkbox"/> Overdentures                            |
| <input type="checkbox"/> Other restorative treatment                          | <input type="checkbox"/> Mixed - surgical/restorative/prosthetic |
| <input type="checkbox"/> Single unit  |  |

## Restorative Care (please cross all relevant boxes)

- |  |  |
|--|--|
| <input type="checkbox"/> Aesthetics                  | <input type="checkbox"/> Toothware                         |
| <input type="checkbox"/> Routine care under sedation | <input type="checkbox"/> Other (please give details below) |
| <input type="checkbox"/> Occlusal Problem            | _____  |

IV conscious sedation is available. Does your patient require sedation?  Yes  No

## Investigations (already carried out)

OPG  PA's  Other Radiographs  CT Scan  Are these enclosed?  \_\_\_\_\_

Has the patient been informed of the cost of the consultation/treatment?  Yes  No

Has the patient been informed on the location of LHDP Referral Centre  Yes  No

Would you like to be present at the consultation / surgery?  Yes  No

## Dental / Medical History

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