Dentist Referral Form for Implants & Oral Surgery

the dental health centre

Referring Dentist Details

Referring Dentist's Name .... GDC No. ....

Practice Address ....

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Practice Name .... Practice Telephone ....

Practice E-mail .... Practice Fax ....

Patient's Details

Patient's Name .... Patient's DOB ....

Patient's Address ....

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Patient's Telephone .... Patient's E-mail ....

Relevant Medical History (please include known allergies and current medication)

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Treatment Required

Comments/Region:

- ☐ Implant assessment, placement & restoration ....
- ☐ Implant placement & refer back for restoration ....
- ☐ Full mouth reconstruction ....
- ☐ Sinus lift(s) ....
- ☐ Guided bone regeneration ....
- ☐ Block bone grafting ....
- ☐ Soft tissue grafting ....
- ☐ Extraction & socket preservation ....
- ☐ Impacted tooth extraction ....
- ☐ Apicectomy ....

Additional Information

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