Implants
Referral Form

Glumangate Dental Practice
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Patient Details
Title:
First Name:
Last Name:
Address: Postcode:
Date of Birth:
Home Telephone:
Mobile Telephone:

Referring Dentist Details
Name:
Practice Name:
Practice Address/Stamp:

Radiographs
☐ Please enclose relevant radiographs

Medical History:

Drugs:

☐ Smoker ☐ Non-Smoker

Reason for Referral:

☐ Extraction Required (with Periotomes)

Tooth/Teeth Requiring Implants;

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

Or

☐ Implant-Fixed Denture ☐ Implant-Retained Denture

Please tick if you need more:

☐ Implant Referral Forms ☐ Cone Beam CT Scan Referral Forms

☐ Periodontal Referral Forms ☐ Periodontal Patient Information Leaflets ☐ Periodontal Care Pathway