# Implant Referral Form

**Referring Practice:**

Address:.....
.....
.....

Work Phone: ..... Mob phone (optional: .....
**Referring Dentist:**
GDC No: ..... Email Address: .....
Signature:..... Date:.....

**PATIENT DETAILS:**
Title:..... ..... Name: .....
Date of Birth: ..... ..... Possibility of pregnancy: yes / no
Address:.....
.....
.....
Home Phone: ..... ..... Work or Mobile Phone: .....

**RELEVENT MEDICAL HISTORY:**

**TYPE OF REFERRAL** (please circle)

Consultation Single Implant Multiple Implants

**CLINICAL SITUATION** (please circle)

Failing Endodontics
Failing Crown & Bridge
Fractured Root
Unstable Denture
Aesthetics
Long standing spaces

**TEETH/SPACES TO BE TREATED**

**Has the patient been informed of the required level of investment?**

YES NO