THE DENTURE & IMPLANT CLINIC

Implant Referral Form

LEVEL OF REFERRAL

Level of referral (please tick as appropriate):

☐ Opinion Only ☐ Maxilliary ☐ Mandible ☐ Partial

☐ CT Scan only ☐ Right ☐ Central ☐ Left

☐ Augmentation Only: ☐ Sinus ☐ PRGF

☐ Ridge Augmentation

☐ Soft tissue corrections (describe below)

☐ Surgical Referral (implant placement and uncovering)

Do you wish to place abutments and provisional prosthetics ☐ YES ☐ NO

☐ Full case Referral (Patient to be referred back to your care on completion)

☐ Radiographs enclosed?

Any Other Details: ______________________________

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Referring Dentist Name: ______________________ Signature: ______________________

Date: ______________________________

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