IMPLANT REFERRAL FORM

avalon

PATIENT DETAILS

Full name .....

Address .....

.....

.....

Postcode .....

DOB .....

Phone .....

Email .....

DENTIST DETAILS

Full name .....

Address .....

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Postcode .....

Phone .....

Email .....

Signature ..... Date .....

RELEVANT MEDICAL HISTORY (INCL. SMOKING STATUS)

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REASON FOR REFERRAL

- ☐ Opinion only
- ☐ Single tooth missing
- ☐ Totally endentulous jaw(s)
- ☐ Multiple teeth missing
- ☐ Full mouth rehabilitation
- ☐ Upper
- ☐ Lower
- ☐ Both

Types of implant retained restoration which have been explained to the patient

- ☐ Single tooth implant
- ☐ Implant & tooth retained bridge
- ☐ Partial overdenture
- ☐ Full restorative case including perio, prostho & implants
- ☐ Implant supported bridge
- ☐ Hybrid prosthesis
- ☐ Full overdenture

INVESTIGATIONS (please tick as appropriate)

☐ OPG ☐ PA's ☐ Other radiographs ☐ Are these enclosed? ☐ _____

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

REFERRING DENTIST

Referring dentist .....

Practice address .....

.....

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Date referred .....

Telephone .....

Fax .....

Email .....

Please return this completed referral form to: Avalon Dental and Implant Centre, 6 Goffs Park Road, Southgate, Crawley West Sussex, RH11 8AY t. 01293 616414 e. reception@avalon-oral.co.uk w. www.avalon-oral.co.uk