GRACEFIELD DENTAL – IMPLANT REFERRAL FORM

Patient's name

Date of birth

Address

Tel number

Email

Patient's complaint / reason for referral

Relevant medical history

Level of referral (please tick as appropriate)

☐ Opinion only ☐ augmentation only ☐ Sinus ☐ Ridge augmentation

☐ Soft tissue corrections ☐ Surgical ref (implant placement and uncovering)

Do you wish us to place abutments and provisional prosthetics? YES/NO

☐ Full Case Referral

Specific date for completion of treatment

Name and address of referring dentist

Tel no: Email:

Signature: Date of referral: