

implant / restorative / sedation referral form

Practice Details

Referring Practice: _____ Date Referred: _____
 Referring Dentist: _____

Patient Details

Patient's Name: _____ Email: _____
 Patient's Address _____
 Telephone Numbers: Home: _____ Work: _____ Mobile: _____
 Date of Birth: _____ Is this referral urgent? Yes No

Implants - Reason for Referral (please cross all relevant boxes)

- | | |
|-------------------------------------------------------------------------------|---------------------------------------------------------------------|
| <input type="checkbox"/> Assessment/Advice/Treatment planning only | <input type="checkbox"/> Multiple units |
| <input type="checkbox"/> Implant surgery and associated restorative treatment | <input type="checkbox"/> Overdentures |
| <input type="checkbox"/> Other restorative treatment | <input type="checkbox"/> Mixed - surgical/restorative/prosthdontics |
| <input type="checkbox"/> Single unit | |

Restorative Care (please cross all relevant boxes)

- | | |
|------------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> Aesthetics | <input type="checkbox"/> Toothware |
| <input type="checkbox"/> Routine care under sedation | <input type="checkbox"/> Other (please give details below) |
| <input type="checkbox"/> Occulsal Problem | _____ |

IV conscious sedation is available. Does your patient require sedation? Yes No

Investigations (already carried out)

OPG PA's Other Radiographs CT Scan Are these enclosed? _____
 Has the patient been informed of the cost of the consultation/treatment? Yes No
 Has the patient been informed on the location of LHDP Referral Centre Yes No
 Would you like to be present at the consultation / surgery? Yes No

Dental / Medical History

