IMPLANT REFERRAL FORM

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Dr. Barry Holmes
Implant & Aesthetic Dentistry

Patient details

Name: .....
Email: .....
Date of Birth: .....
Home Telephone: .....
Address: .....
Work Telephone: .....
Postcode: .....
Mobile Telephone: .....

Dentist details

Name: .....
Postcode: .....
Practice Address: .....
Telephone: .....
.....
Email: .....

Reason for referral

Implant Consultation ☐
Implant(s) placement: ☐
Bone augmentation: ☐
Soft tissue grafting: ☐
Sinus augmentation (tap/lift): ☐

Enclosures

Peri-apical ☐
OPT ☐
CBCT scan ☐
Photographs ☐
Other (study models, STL files, DICOM files) ☐

DATE OF REFERRAL ...../...../.....

Patient's main complaint/concern: .....

Brief clinical description of problem: .....

.....

Medical history: .....

.....

Preferred referral clinic: Cardiff ☐ Swansea ☐

Do you wish to restore the implant(s)? ☐ ☐

Are you happy for restorative treatment in adjacent teeth to be completed? ☐ ☐

Any preference for type of retention for the prosthesis? Screw-retained ☐ Cement-retained ☐

OFFICE USE ONLY

Referral received on .....
Patient contacted by: Tel ☐ Mob ☐ Email ☐

Enclosures/attachments received Yes ☐ No ☐
Dentist notified: Yes ☐ No ☐

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ITI International Team for Implantology