IMPLANT REFERRAL FORM - 01352 762183

LIMEWOOD DENTAL CARE

Please complete and return via email (Subject Line: 'IMPLANT REFERRAL'): info@limewooddental.co.uk

PATIENT DETAILS

Full Name: _____ Date of Birth: _____

Address & Post Code:

Telephone Number(s): **E-mail Address:**

RADIOGRAPH/CBCT INCLUDED?

Can you include any recent X-Rays to the referral? ☐ YES **Reason if not ……**	**When these radiographs were taken:**

CLINICAL INFORMATION

CLINICAL REASON FOR REFERRAL. Please detail reason for referral and any relevant history – including any complicating patient factors.

Is the patient periodontally stable? ☐ **YES** ☐**NO**

Is the tooth still present? ☐ **YES** ☐**NO**
If no, when was it extracted? _____

Would you like to restore the implant yourself? ☐ **YES** ☐ **NO – We will restore the implant at Limewood**

If any pre-restorative treatment needs completing prior to placing the implant (for example: replacement crowns, fillings, build ups or management of toothwear), would you like this to be done by Dr Massi at Limewood Dental Care or would you like us to liaise with you/refer the patient back to you to complete:

MEDICAL HISTORY / MEDICATION(S) / ALLERGIES – anything which is relevant.

Smoker ☐ - How many per day? **Ex-smoker** ☐ - When did they stop? How long did they smoke for?

REFERRER DETAILS

Full name and GDC Number:

Practice Name/Address:

Telephone Number:

E-mail Address:

Fees

Implant Consultation – £95
Single Implant - From £3285
CBCT Scan - From £195

If you have any questions, please contact Massi Sarogni on 07746 670 745.

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