**IMPLANT REFERRAL FORM**

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| **PATIENT DETAILS** |
| Patients Title and Name | Age of patient in years | Sex | Date of Birth (DD/MM/YY) |
| Patient Address |
| Mobile Telephone Number | Home Telephone Number | E-mail address |
| **REFERRAL INFORMATION** |
| Referring Dentist Name | Referring Dental PracticeCrewe  | Date of decision to refer |
| GDC Number of referring dentist | Does patient require sedation? Yes No  |
| **RADIOGRAPHS** |
| I can confirm diagnostically acceptable radiographs have been sent with this referral Bitewings Periapical OPG None (reason required) Reason if no radiographs........................................................................................................................................... |
| **TREATMENT REQUESTED** |
| Reason for referralImplant assessment advice Implant problems and diagnosisImplant surgical placement only Augmentation and surgical placementToothImplant surgical placement and restoration OtherBrief description of treatment required:......................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................... |
| **ADDITIONAL INFORMATION** |
| Relevant medical information, ie medication including dosages, allergies etc | Is the patient a smoker?Yes No |
| **PATIENT CONSENT TO REFERRAL** |
| Has the patient understood and consented to the referral? Yes No |   |
| **CONFIRMATION AND SIGNATURE OF REFERRING DENTAL PRACTITIONER** |
| Print Full Name..............................................................................................Signature...................................................................................................... | Date.......................................... |

Please send all referrals to the following address:

Site Lead

Referral Centre

Alchemy Dental Practice

203 Edleston Road

Crewe

Cheshire

CW2 7HT

Alternatively, referral forms can be emailed using the email address: info@alchemydental.co.uk with ‘FAO of Site Lead’ in Subject line.